Refer 7.5 User Manual

Version 3.0
Edited 12/1/15

Contents

REFER 7.5 TRAINING

Version 3.0

Contact Module

Contacts for Refer 7.5 Version 3.0

System Administrator: Tina Ricketts: (603) 621-6892 Associate Director/Resource Database Manager 211NH Contact System Administrator with problems or issues with the content of the Refer database.	Tina.ricketts@211nh.org
RTM Designs Help Desk: Contact RTM directly for problems or issues with the functionality of Refer, problems logging in and difficulty printing from Refer. All Systems issues are reportable via the system support portal in the contact module in Refer7. RTM Phone Number (888) 933-5052	steve@rtmdesigns Julie@rtmdesigns Or access the Support System to enter a trouble ticket
Wendi Aultman: (603) 271-9680 Program Manager, ServiceLink	waultman@dhhs.state.nh.us

Updated 12/1/15

Screenshots disclaimer:
The screenshots in the Refer manual version 3.0 are up-to-date and accurate as of 12/01/2015. User experience may differ slightly as new items are added or old items removed.

Introduction

What are Refer7 and Refer Web?

ReferWeb is a turnkey Internet software system that searches for, locates, and displays Human Service Provider information from your organization's Information & Referral Resource database. ReferWeb offers several user-friendly search methods to accurately locate Service Providers :

- **Category/Subcategory**
- **Taxonomy or Keyword**
- **Agency and Site Name**
- **AKA Name**
- **Program Name**
- **Area Located**
- **Area Served**
- **Conditions and Filters**

ReferWeb is completely customizable. You decide on the font style, graphics, and page layout and even customize the search features. ReferWeb integrates seamlessly with your current Web Site. ReferWeb tracks and reports user statistics such as web hits, Zip Code, city, age, gender, services searched, and service provider's users are viewing.

Background on RTM Designs

In June 2002 RTM Designs purchased Alliance System's Web-based Information & Referral programming division to further enhance the PC product line and Web service capabilities. The RTM Designs Web programming team develops customize I&R Internet applications and offers I&R Web systems that are available "right of the shelf"

What does RTM Designs do?

RTM Designs is the world's premier technology developer of Information & Referral/Client Tracking software using Microsoft solutions in the enterprise. RTM Designs creates value for its customers by leveraging Microsoft enterprise technology to design, build, and deploy generic and customized PC and Internet based Information & Referral software applications using reliable architectures and scalable infrastructures to increase profitability, improve speed-to-market, and accelerate growth. RTM Designs is focused on helping 211 customers as well as other comprehensive and specialized I&R customers increase the efficiency of their day to day I&R operations.

What is the ServiceLink Network's relationship with RTM Design?

The State of New Hampshire (DHHS) leases Refer7 software from RTM. RTM gives the ServiceLink Network software support during business hours. RTM also provides database back-ups for all of the data that the Network inputs into the Refer7 system.

Why Does ServiceLink use the Refer7 System?

ServiceLink uses Refer7 as it's centralized resource database in order to assist users with resources Statewide and also to assist with documentation of calls/contacts. The Refer7 system allows users to track client records and also to generate reporting data on those contacts.

Creating a Remote Desktop Shortcut

1. Getting started on your Windows 7-based laptop or desktop computer.

On your laptop or desktop computer, click on the Start menu, navigate to All Programs, then to Accessories, and then launch "Remote Desktop Connection."
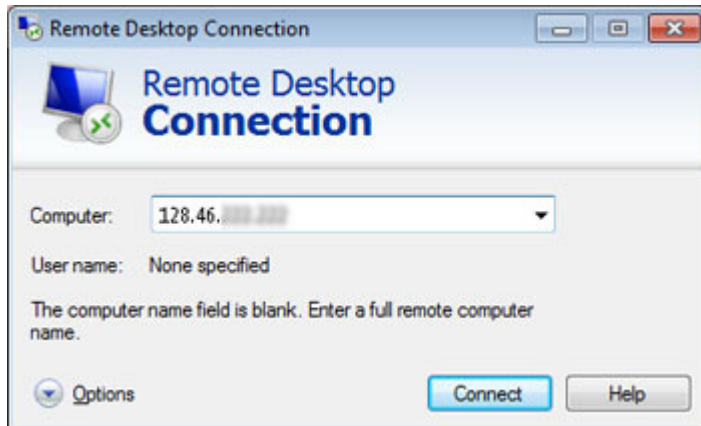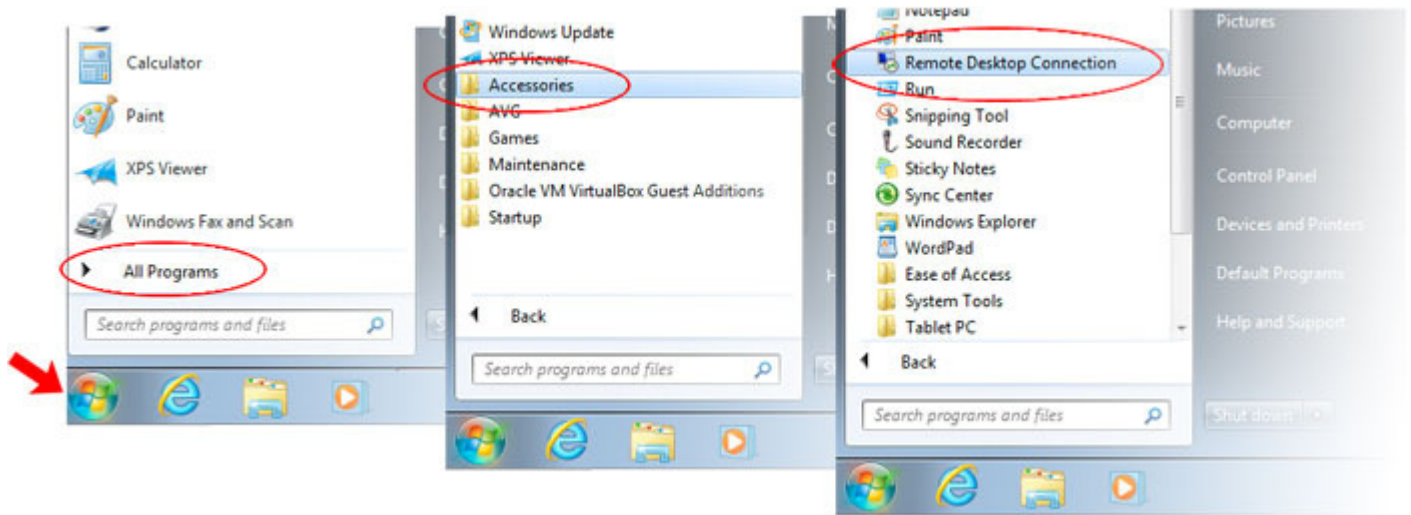

2. Computer address.

2A. In the "Computer" field, enter rtmcentral.net. If that connection does not work you may try rtmcentral1.net

You may either skip to step #6 (to connect to the remote computer immediately) or proceed with step #2B (to set program options and create a shortcut for future use).

2B. Then click on the "Options" button. The window will expand to show several tabs, each with various program settings.
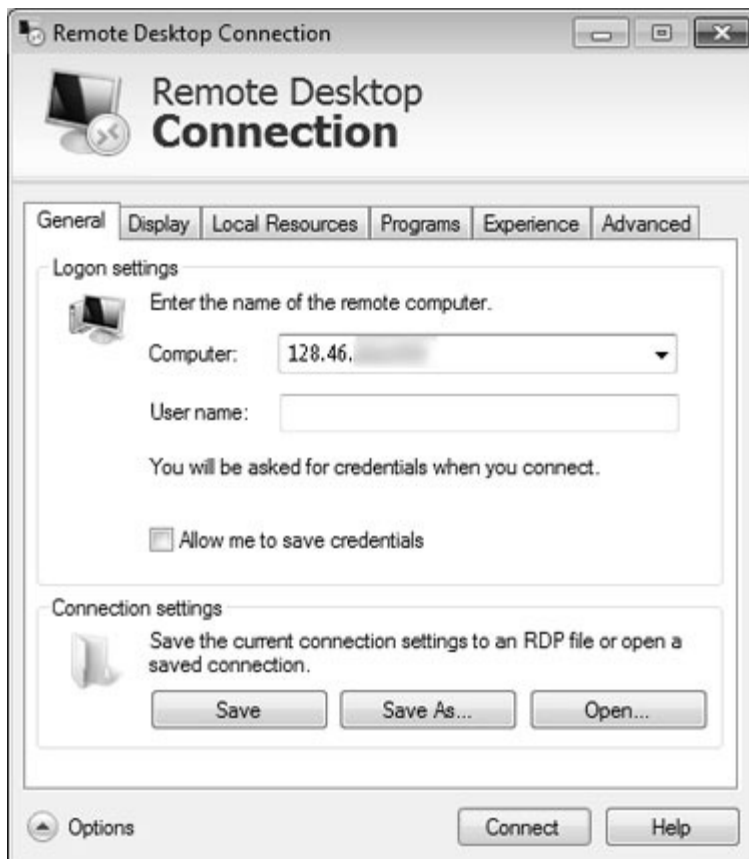
3. The "General" tab.

3A. The username field will be formatted in the following way. rtmdesigns\slso.lastname.first initial. Note that the slso will be different for you depending on the office you are in. See your supervisor or the database administrator for your complete username and password

Leave the "Allow me to save credentials" box unchecked.

3B. Click on the "Save As" button to proceed to the next step. The "Save As" dialog will appear.

3C. Optionally, you can visit the Display tab and change the resolution of the Remote Desktop (Refer) window and make it bigger or smaller.

4. Saving your shortcut file.

In this step, you'll create a shortcut file which you will later begin using routinely to launch a remote control session to your office PC. You may save this shortcut wherever you prefer; we suggest saving a copy to your desktop.

4A. In the "Save As" dialog, click on the "Desktop" icon in the left-hand column. This will set the "Save in" location to the desktop.

4B. In the "File name" field, type a name that you'll recognize. We suggest something like the following:

Refer 7

4C. Click the "Save" button.

The new shortcut file will be created on the desktop.

4D. (This step is optional.) If you'd like the shortcut to appear in more places, this would be a good time to make copies of it. You could drag the icon from the desktop to the Start button, for example, to place a copy of the shortcut in your Start menu.

**Connecting to the desktop computer in your office**

These instructions assume that your computer is connected to the Internet, either wirelessly or via a broadband connection (e.g. cable modem or DSL).

5. Starting the remote connection.

5A. If you saved the icon to the desktop in step #5, locate it there and double-click the icon now.

Alternately, repeat steps #1 and #2A, and then click the "Connect" button.

Your laptop or desktop computer will connect via the Internet to your desktop computer in your office.

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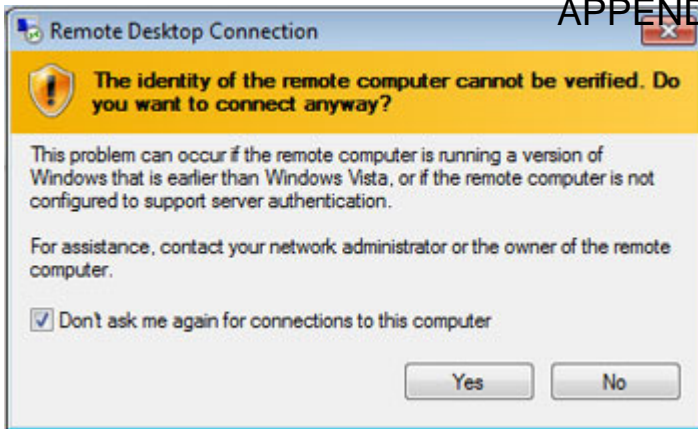
8. Remote computer verification.

You might see a dialog (like the one shown above) noting that the remote computer's identity cannot be verified.

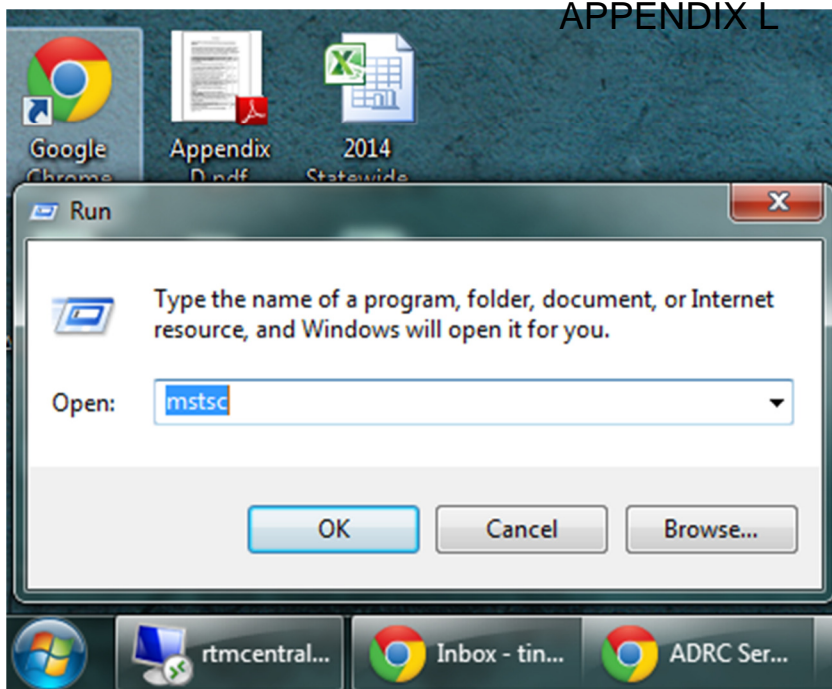**8A**. It will not do any good to check the Don't ask me again… check box as it will not save.

8B. Click the "Yes" button then you will be redirected into the Refer window to sign in using the same username and password you used previously.

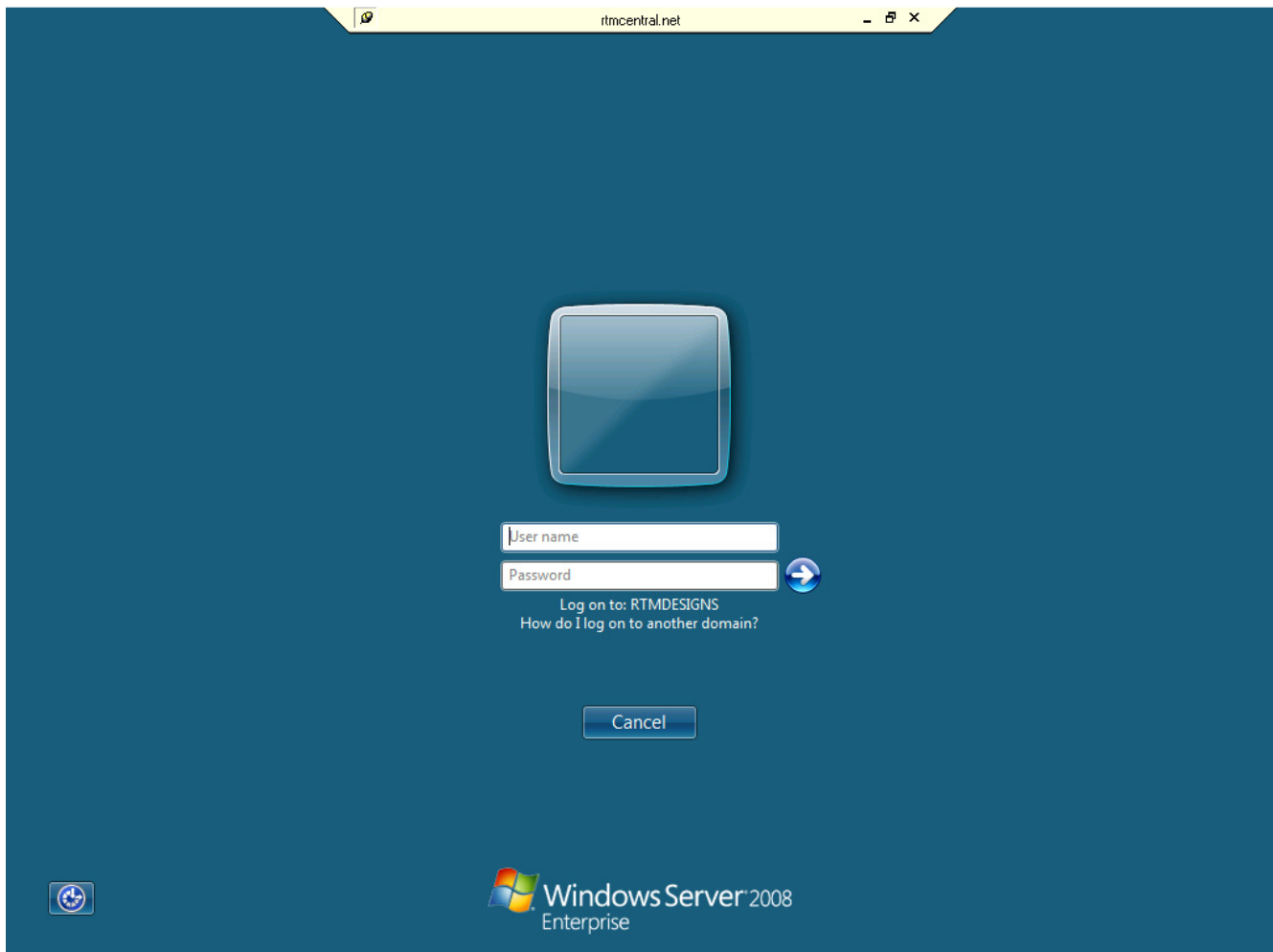# Accessing Refer with no Icon

Windows button in Task Bar
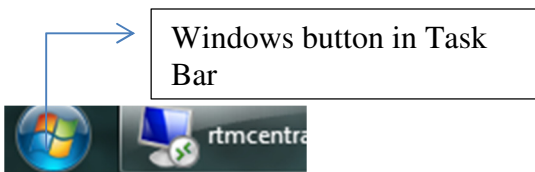
Click on the start button or the Windows button
Either click on "Run" and in the pop up box enter "MSTSC" without the quotes and click on OK; or just type in the box that states "Search programs and files". Proceed with log in as usual.
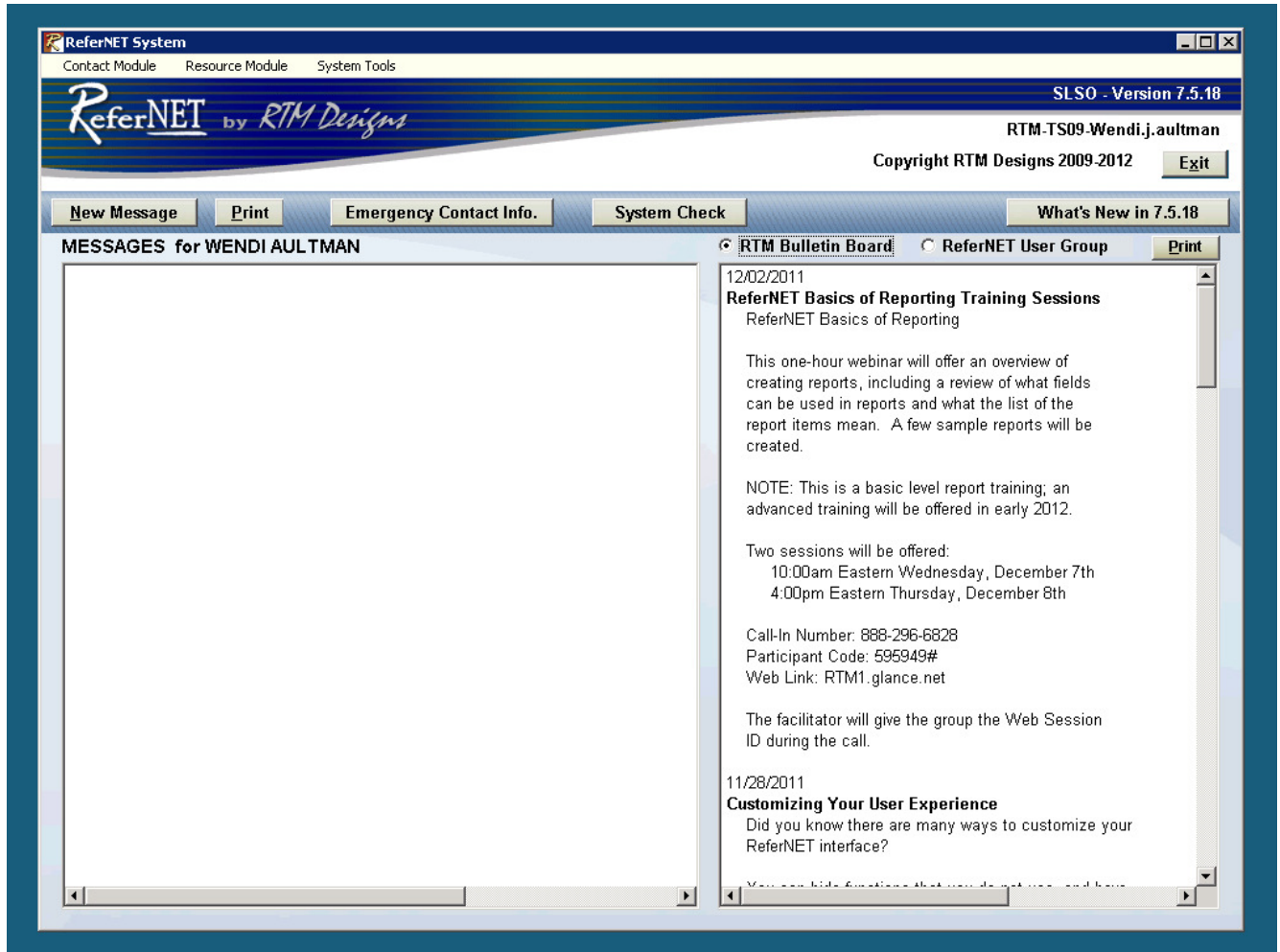
Log-In

rtmcentral.net

User name

Password

Log on to: RTMDESIGNS
How do I log on to another domain?

Cancel

Windows Server 2008
Enterprise

Once you have typed your **User ID** and **Password** hit "enter" on your keyboard or the "arrow" on the screen. If you forget your password notify the System Administrator to reset it.

- Depending on your operating system this screen may appear differently, however user name and password will remain the same. If you see a drop down box under the password box, at this point, (primarily used when logging in with rtmcentral1.net) select RTMDESIGNS rather than the option of "This Computer"
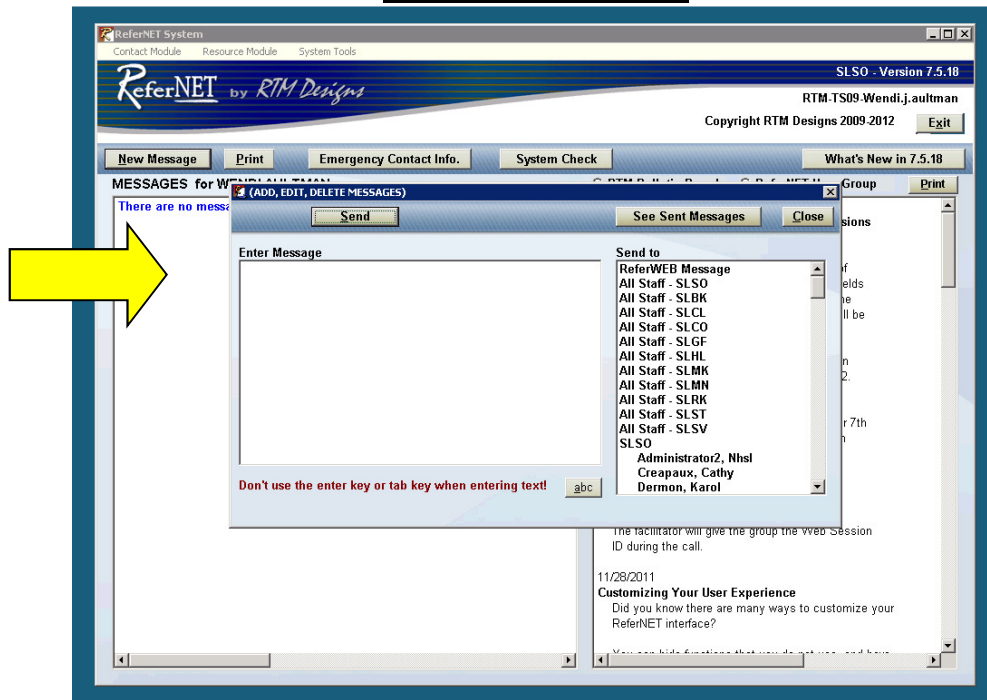
Message Board

The **Message Board** automatically appears when you login to the system. You will not be alerted of new messages until your next login or if you manually go to the **Message Board** by exiting the contact module. It may be necessary to log out and log back in to view the most current messages posted.

The **Message Board** is **NOT** a good way to send another staff person a quick question. They may not see it until the next day. Either call or send a personal e-mail if an immediate response is required.

If you place a message on the **Message Board** remember to delete it when it is no longer applicable. 1 week is the standard guideline.

You can also delete messages that have been sent from another staff member as soon as you read them. To delete a message, click on text; a pop up box will appear. Click yes.
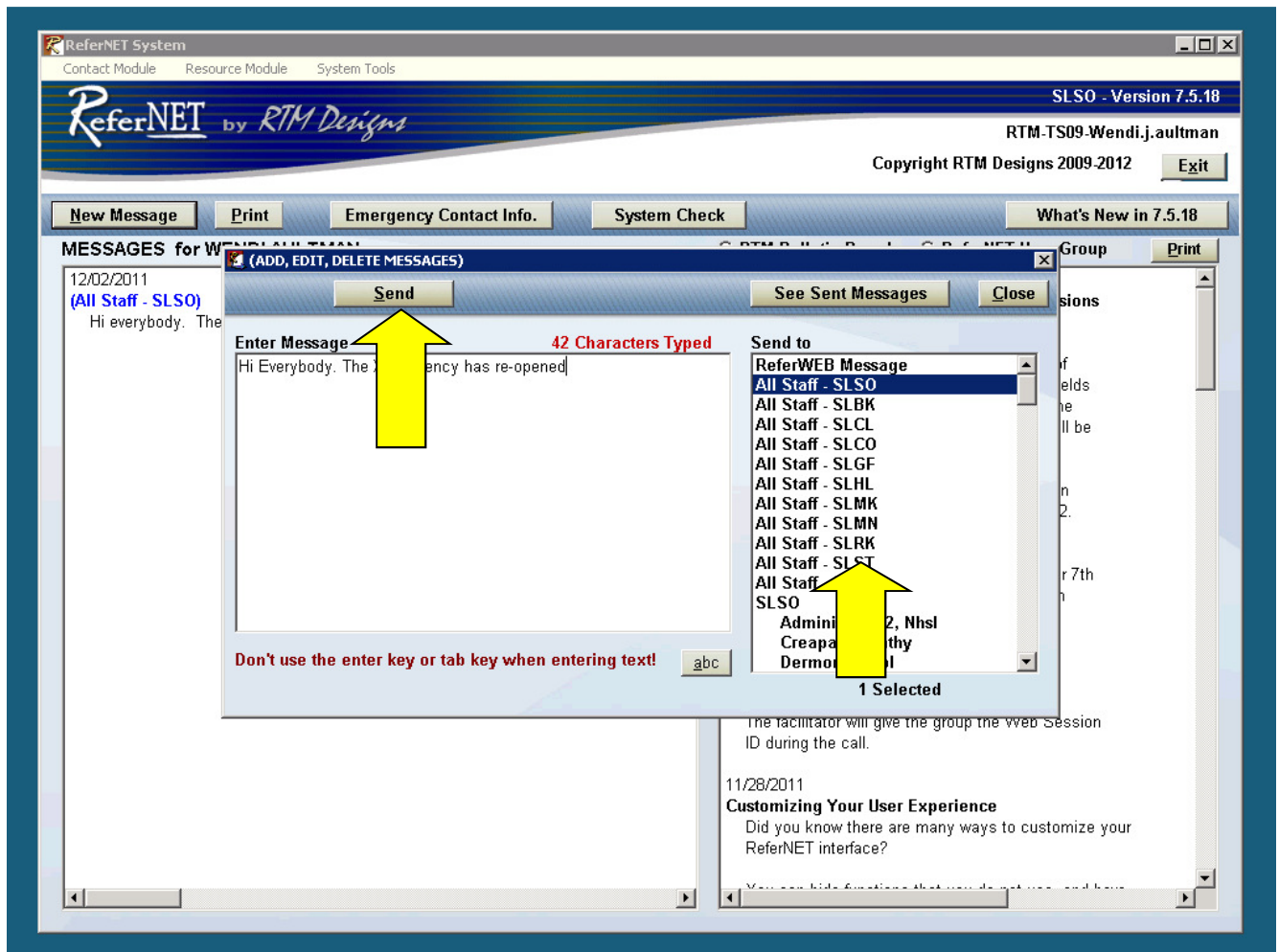
Message Board

The message board can be used to send a message to one staff person or all staff in an SLRC office. To do so, click on 'New Message'. Click on messages to activate the option to delete them. Go to sent messages to review previously sent messages and to DELETE the messages. Messages are not "real time". You must log out and log back in to see messages.
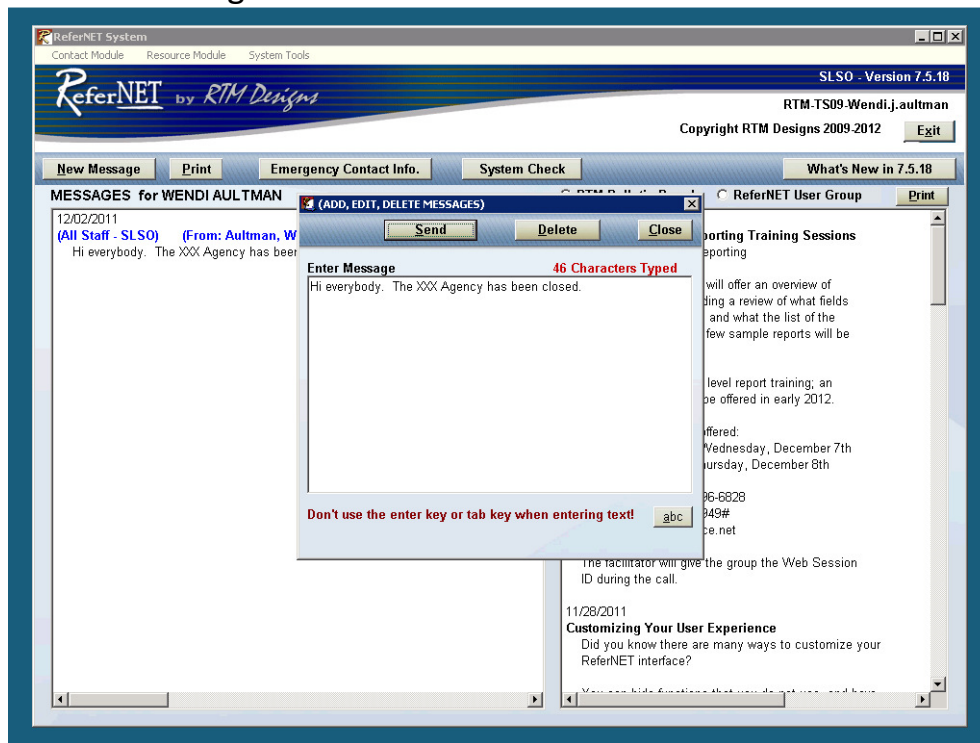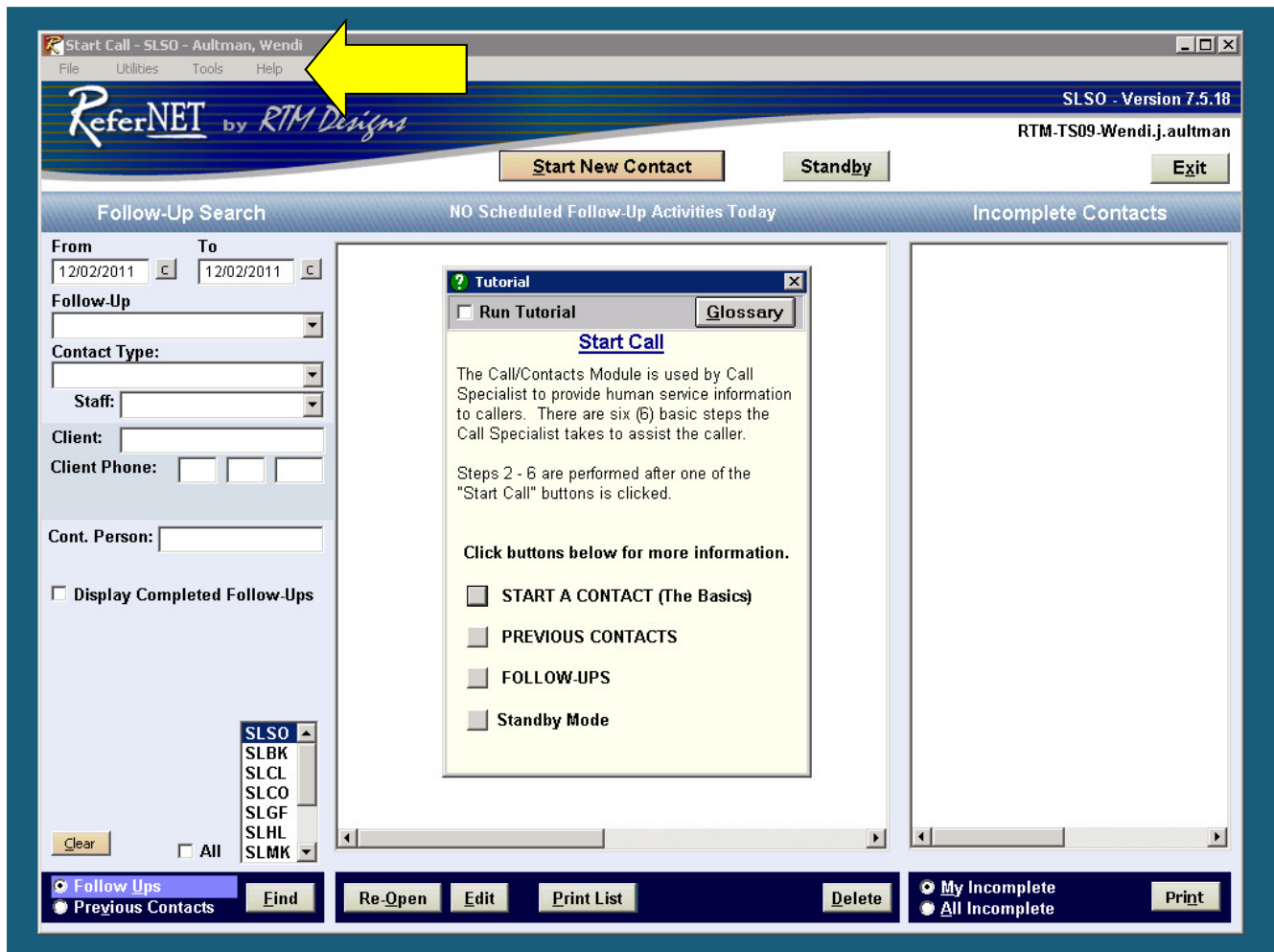
Type your message, choose which staff or office to send the message to and click **Send**.

The **Help** button, identified as **the word help at the top menu bar** is available on every screen in Refer7. The information that the **Help** feature provides can be used in support of the Refer7 paper manual.

There is a glossary of terms, tutorial session availability, and functionality guidance available for each page.

Glossary

Action: An action is one of three types of assistance a SLRC staff person gives to a contact. At least one of these actions must be saved to record a call to the Refer7 database.

- Referral
- Unmet Need
- Reason for Call

Contact: When a staff person at the SLRC is contacted by telephone call, walk-in (responds to a person who drops by the office without an appointment), home visit, appointment (in office or in community setting), email, letter or fax with a person looking for resources.
> NOTE:
1. **Calling or contacting agencies on behalf of a contact person is not a contact.**
2. **Contacting BEAS with questions regarding your work with clients is not a valid contact in refer7**
   > **Example**: A contact person is working with the I&R Specialist. As a result of this call the I&R Specialist need to research and advocacy on behalf of the caller. In order to do this, the I&R Specialist calls 4 agencies to gather information and get back to the contact person. The calls to agencies are NOT additional contacts in the Refer7 system.

Contact Person: The person initiating the event from the community.
Types include: Caregiver, friend/relative, provider, govt. agency, community group, self, and other.
Caregiver - Family members or friends, usually uncompensated, who assume responsibility for attending to the daily needs of individuals who are temporarily or permanently unable to completely care for themselves due to general frailty; illnesses, injuries or progressively debilitating conditions such as Alzheimer's disease or mental illness; or other incapacitating problems.
Community Group - Organizations or groups of individuals who have common interests or concerns who have joined together on a voluntary basis to provide targeted services for the community, e.g.: religious groups.
Friend/Relative - An individual who has a personal relationship with the person who they are calling about but are not that person's caregiver.
Government Agency - An entity, by which a community or other political unit is governed, can be town/city/county/state/federal.
Hospital-A worker contacting ServiceLink from a hospital
Nursing Facility- A worker contacting ServiceLink from a nursing facility
Provider – A worker from an entity that provides services to our clients.
Other - Callers who are not categorized in any of the above.
Self- An individual calling on their own behalf.

Client: The client is the person the information or resources are being sought for. In cases where the contact person is calling for himself or herself the contact would be the client.   The contact may be calling for information or resources that will help someone else not themselves; in this case, "someone" is the client.
Client types include: Caregiver, disabled adult, friend/relative, older adult (60 or older), provider, and unknown.

ServiceLink Resource Center (SLRC) Information and Referral Service: Organization whose primary function is to link people in need of human services with appropriate service providers who can meet their needs. These services can be comprehensive, covering the whole range of human services or specialize in resources for a particular population.

Note: For terms not defined above, the Glossary Definitions as stated in the AIRS Standards for Professional Information and Referral Systems will be used. (See attached)

APPENDIX L

Information Provision: The information provision is the process of providing descriptive information about a service provider to the inquirer. Information can range from a limited response (name, telephone, address), to detailed data about community service systems (such as explaining how a group intake system works for a particular agency), agency policies, and procedures for application.

Examples of Information provision include: (for more detail go to page 29 of the Refer7 Call Module)
- ❖ Responding to a request for the number for a food pantry. **(Basic needs information)**
- ❖ Responding to a question: what home health agencies are available in my town?
- ❖ Responding to a request for a ride to the doctor's office.
- ❖ Responding to a request for phone numbers or addresses. **(Service Provider Info)**
- ❖ Assisting a contact with directions.
- ❖ Assisting a contact with CFI education.

Referral Provision: The process of assessing the needs of the inquirer, identifying appropriate resources, assessing appropriate response modes, indicating organizations capable of meeting those needs, and providing enough information about each organization to help inquirers make an informed choice. Helping inquirers for whom services are unavailable by locating alternative resources, and when necessary, **actively** participating in linking the inquirer to needed services by scheduling appointments, three-way calling, or negotiating for the inquirer. This will be recorded by way of the total referrals made by staff for a person contacting the SLRC.

Total Amount of Time Spent: Total amount of time spent on the system processing events is recorded in IT system automatically once a staff person opens a call. Time for events that are managed on the Refer7 system such as home visits, scheduled appointments, long-term support counseling, research, travel, etc. will at all times be added to the contacts captured in Refer 7 by editing the contact and adding the extra time.

Follow-up: The process of contacting a contact or client to determine whether the resources they were referred to met their needs. At all times staff will fill out the unmet need screens for those referrals that did not help.

<mark>Keep in mind:</mark>

<mark>**If a caller/contact calls requesting a specific phone number, it falls into the information provision, even if you need to look it up using Refer7 using the search screens or the resource module.**</mark>

Entering Contact Module
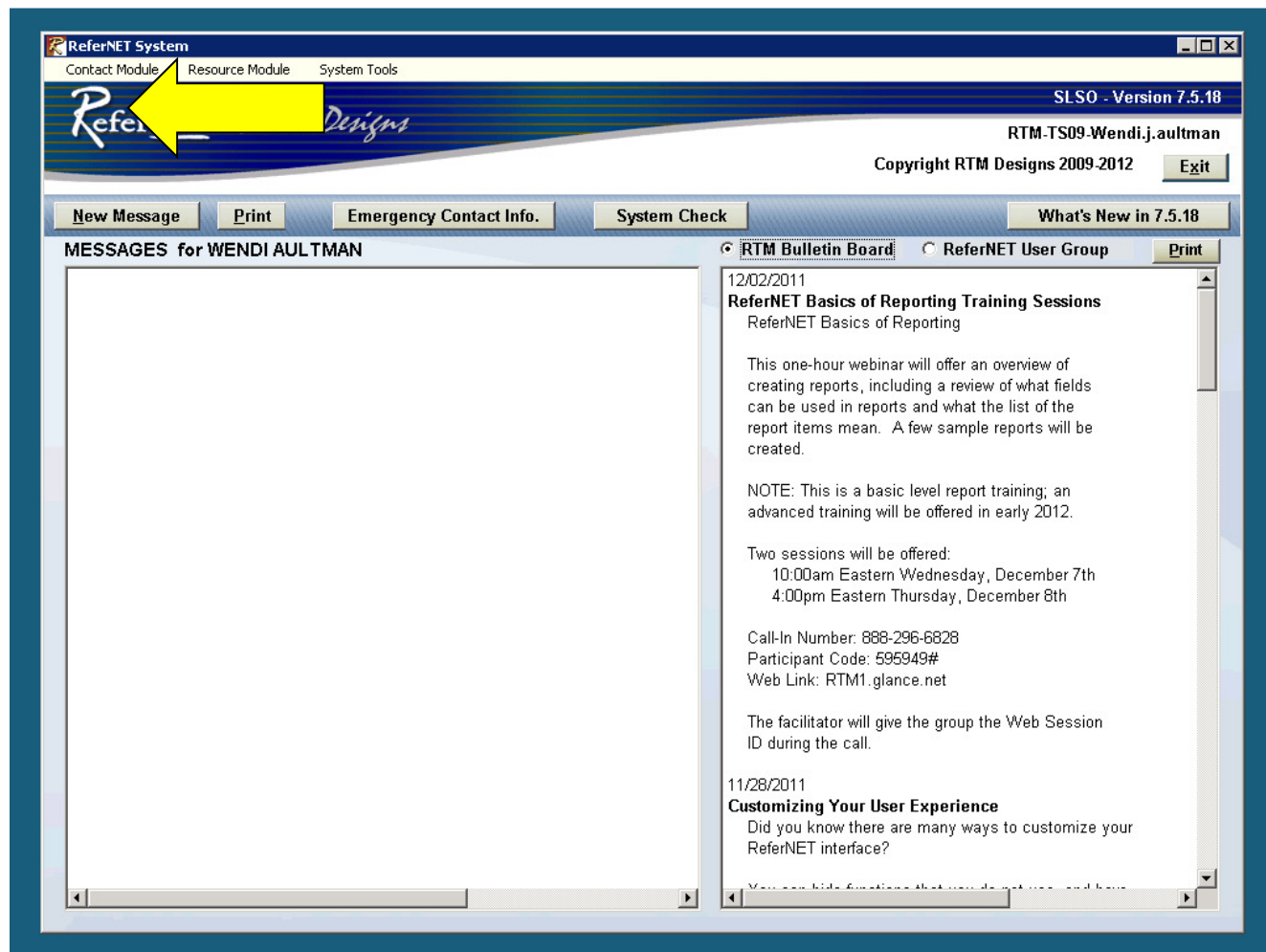
To access the 'Contact Module', single click on 'Contact Module'

Dashboard: Standby Mode

'Standby Mode' will allow you to view all screens without creating a permanent record.

Documenting a Contact

From the Contact Module you can:

- Start a call/contact
- See previous calls
- See your scheduled follow-ups
- See your incomplete calls

Click on "**Start New Contact**" to begin an event. Clicking this button initiates an internal clock that date stamps the event with your name. It tracks the time spent on the contact from start to finish.

Documenting a Contact

3.Data Page

The Contact is divided into 3 sections:

Search

People

Data (noted by yellow arrow)
The buttons are located in the top left corner of your screen. When **'Start New Contact'** is clicked you will be brought to one of three pages. You may click on any of the three pages to begin entering in contact information.

Shown above is the 'Data' page. This page contains a box to write your contact notes, a list of the data forms, Contact Markers, and a list of forms saved for the caller during the contact and client.

'Contact Markers' and 'Contact Data Selections' are required to be completed for reporting purposes. There are sections of the SL Contact form that are not required if the contact person in already known in Refer7.

Documenting a Contact

3.Data Page

3.Data Page

Contact Notes

If you complete notes under Contact Notes remember that the notes are not saved in the permanent client record. The note is attached solely to the call that you are in. You can complete notes in Contact Notes but you may want to copy and paste those notes into the Client Activity and Notes Page. **Be sure to Add Date and Staff All calls, except 'Quick Calls' must have information entered in 'Client Activity and Notes Page.'**

Contact Markers

How was contact initiated?

Note:
- Out of State(OOS)/Cell call is used by the <mark>Merrimack County office **ONLY**</mark> as they triage calls unable to be directed to the appropriate SL site.

Contact Data

This box contains data collected in order to report where a contact heard about ServiceLink, and if they are a first time caller.

Documenting a Contact

2.People Page

2. People contain information about the client and the caller. The Client is the person in need of the services. The Contact is the person calling on behalf of the person needing assistance.

<mark>On the left side is "**Quick Client Info**", for anonymous clients who you are only working with briefly and will not need to retrieve in the future. Use this form to enter the information you will need to target your search for services.</mark>

==**Do not use the Quick Client Info form if you want to be able to find this client in the future. The call and all information will be saved, but the client will not be added to the client database.**== When using 'Quick Client Info' you will have access to pages 1, 2 & 3. You will not have access to '**Client Notes and Activity**' as a client is not saved, only activity and time. You can document in '**Contact Notes**' on page 3.

To find a caller, click the button, **Find Contact.**

To find a client, click the button, **Find Client.**

Documenting a Contact

2.People Page-Search for Contact/Client

The Client/Contact search function works the same for both the Contact and the Client. To minimize duplicate entries, search by last name, telephone number, or social security number. Try multiple searches before adding new client. *Note-The "%"

(percentage sign) can be used as a wild card and can take the place of any letter or string of letters.

If your search identifies the caller or client, click '**Select'** or double click on client, to select their record. If client is not in database click '**Add New'**.

<mark>***Less is best when searching to minimize duplicate calls**</mark>.

Documenting a Contact

2.People Page-'1.Person's Info'

When you select '**Add New**' a separate window appears to capture information about the caller and client to include:

- Name
- Demographics
- Telephone number
- Gender
- Date of Birth

CLIENT Markers are to be used to identify special indicators for data collection purposes. (For more information see section 4 refer 7 policies and procedures)

ROI means release of information. Check this when you have either verbal or written permission to share information.

Address on the "left" should be the mailing address and address on the "right" should be the physical address if different.

When adding a new client additional information is necessary. Notice the **right side** of the screen where 'client data', 'Medicare information', 'race/ethnicity' and 'client markers' are represented.

Documenting a Contact
2.People Page-'1.Person's Info'

When documenting the **Client Type** choose the option that best describes the reason that an individual is calling at that time. Clients can be more than one client type, but tend to call about a particular reason.

*__Organization__ is important to fill in. This will indicate a provider and they should not get consumer satisfaction surveys. It will also indicate hospital, nursing facility, or other agency name, which is important when reviewing data.

*__Organization section can be used to indicate or flag a person who should NOT get a Consumer Satisfaction Survey. Acceptable flags are as follows: Severe Dementia, passed away, Actively working on Medicare Part D.__

==**CAUTION, Not ACCEPTIBLE: still working with client, not ready for a survey, don't send survey among others. If these are identified in staff client records, they will be asked to remove them.==

Once information is completed **'save'** and then '**close**' out of the person's information.

Documenting a Contact

2.People Page-'People Assoc. to this Person'

2.People Page – For additional guidance see Appendix H – Client vs. Contact:Which is Which

When the client is the contact person click 'Client is the Contact Person'. When doing so client information will auto populate into the 'Contact Person'. When the Contact Person is not the client you will have to associate the contact to client. To do so, click on 'Add' and a relationship box will appear allowing you to define the relationship.

==Additionally, you can associate numerous clients to one contact person. One contact person may be calling about multiple clients.==

Contact Person Type is also defined on this page and a drop down menu is available.

Caregiver - Family members or friends, usually uncompensated, who assume responsibility for attending to the daily needs of individuals who are temporarily or permanently unable to completely care for themselves due to general frailty; illnesses, injuries or progressively debilitating conditions such as Alzheimer's disease or mental illness; or other incapacitating problems.

Community Group - Organizations or groups of individuals who have common interests or concerns who have joined together on a voluntary basis to provide targeted services for the community, e.g.: religious groups.

Friend/Relative - An individual who has a personal relationship with the person who they are calling about but are not that person's caregiver.

Government Agency - An entity, by which a community or other political unit is governed, can be town/city/county/state/federal.

Hospital-A worker contacting ServiceLink from a hospital

Nursing Facility- A worker contacting ServiceLink from a nursing facility

Provider – A worker from an entity that provides services to our contacts/clients.

Other - Callers who are not categorized in any of the above.

Self- An individual calling on their own behalf.

Documenting a Contact

2.People Page - Client Activity and Notes

"**Client Activity & Notes Page**" consists of a log of client activity history and corresponding **Client Notes**. **Client Notes** will be saved in the client's permanent record and allow staff to maintain a running narrative of the actions taken for this client.

==**'Client Activity & Notes Page' is mandatory**==

Documenting a Contact

2.People Page - Client Activity and Notes

Click on '**Add New Note'**. **Tips When Documenting**

- Concise
- Clear
- Complete

- Fully document each step that leads you to a particular conclusion
- Write the information so that another person reading the note could reach the same conclusion
- Don't put anything in the record that you wouldn't want others to view.
- Be careful when using acronyms and/or abbreviations.

NOTE: This page will be evolving to include Options Counseling items such as an action plan and options counseling tool documentation.

Documenting a Contact
2.People Page - Client Activity and Notes

After selecting 'Add New Note', a text box will appear allowing you to document activity. You have the ability to spell check (**ABC**) your notes. Also, you must 'Save Text' when you have completed your note.

Documenting a Contact
2.People Page - Client Activity and Notes

To edit notes: click on the blue line, which indicates the date and time of the call as well as the writer. When you place your curser on the blue line the note will open up in a text box allowing for edits.

APPENDIX L
Documenting a Contact
2.People Page - Client Activity and Notes –'Review'

The '**Review**' button allows for editing of the date, time and length of call. Therefore, if you are documenting a home visit/call that took place earlier in the day you are able to adjust time for the time spent with the client.

Documenting a Contact

2.People Page - Client Activity and Notes – 'Review'

When you click on the '**Review**' button, a contact page opens. You can edit time and date on this page. You must 'Save' all changes before closing this window.

Call Activity summary is not available for editing on this page.

Tip: When you add time using 'Review', make sure this is the last step before finishing.

Documenting a Contact

Reason for Contact

A call may not result in a referral if the staff person is only providing information or education. Refer7 will not allow you to 'End Contact' a call without there being one of three actions completed: (1) a referral being made, (2) an unmet need being identified, **or** (3) reason for call being selected. When information or education is recorded in a call and there have been no referrals made, the **"Reason for Contact"** screen will automatically come up when you select 'End Contact'.

Once a '**Reason for Contact'** has been selected click on the 'Save Reason for Contact button'. If a referral has been made there is no reason for choosing a '**Reason for Contact'** unless you provided additional provisions in the same contact such as directions to an agency, or education about the process for applying for a service.

There may also be times when a referral is done for a particular service and you also provided information to the caller/client that you want to document in the system. You can access the '**Reason for Contact'** screen manually under these circumstances.

You can also have and save more than one '**Reason for Contact**'. For example, you provided information or education about assisted living and food and you will want to document both. These would be recorded as **LTC info** and **Basic Needs info**.

"**Reason for Contact**" should not replace the use of taxonomy in recording a contact. The use of "**Reason for Contact**" should be reserved for use when no taxonomy applies or for actions not requiring a taxonomy search.

Additional Detail About The Reason For Contact category

Reason for Call	Definition
Affordable Care Act Information	Information and education about the Affordable Care Act
Basic Needs Information:	Housing Education - Home Assistance – Fuel Education – Food Education – Transportation Education – Legal Education*
Health/Safety Information:	Dental Education – Health Issues Education – Mental Health Education – Recreation/Social Education – Safety Education – Substance Abuse Education – Wellness/Prevention Education – Legal Education*
Financial Information:	Education/Employment Education – Childcare Education – Financial Ed – Insurance Education – Medicaid Education – Prescription Drug Education – Legal Education*
Service Provider Information/Explanation:	Address Request – Caller Needed Directions – Explanation – Phone Number Request – Verified Fees – Verified Hours – Legal Ed*
Long-Term Care Information:	Assisted Living Education/Explanation – CFI Education – Nursing Home Education – Legal Education*
SMP Fraud Information	Information and education about the Senior Medicare Patrol Program
Medigap Information	Information and mailing for Medicare Supplemental Insurance Plans
New Hampshire Health Protection Program Information	Information and education about the NH Health Protection Program

*Legal Education has been added to every category because legal education needs to be "about" something, it does not stand-alone.

Additional Reason for Call categories:

- Contact with Provider Regarding a Consumer
- Left Message with Consumer/Family
- **Limited 'Case Management': The SLRC Network is currently examining the use and definition of '**

APPENDIX L

Documenting Unmet Need

The unmet need screen is one of the three qualifying activities needed in order to complete a contact. It can be recorded on its own without reason for call or a referral. For example if someone calls about:

- Wanting a ServiceLink staff person to assist with getting (forcing) a loved one to move out of their home
- Wanting to find a service that will assist in getting money back from a store where a loved one spent thousands of $$$ on scratch tickets.

These services such as this do not exist.

If someone is not in immediate risk and his or her basic needs are being met the requested service need is not categorized as a network defined unmet need. **For example: A consumer requests low income senior housing and is put on a waiting list, however they are currently residing in an apartment until there is an opening.**

The ServiceLink Network strives to record contact information uniformly and consistently. Accurate and consistent reporting allows us to demonstrate that the public money invested in ServiceLink is well spent.

Properly recorded information also helps us identify and document needs that cannot be addressed because services are inadequate or non-existent. For ServiceLink Network purposes, "unmet need" indicates that the client experiences negative consequences because the required service does not exist, is not financially or geographically accessible to the client, or lacks the capacity to serve the intended population.

If the client simply "desires" a service, or refuses a referral because they are seeking a "better option," the ServiceLink Network does not regard this as an "unmet need."

Documenting a Contact

3.Data Page. Contact Data

Contact Data should be documented whenever possible. Documenting where a contact heard about ServiceLink provides indicators of success with outreach events, time spent distributing materials and provider and community knowledge and trust based on referrals.

Documenting a Contact

3.Data Page - SHIP Form

NOTE: The SHIP Form is only to be filled out by SHIP Trained Counselors. Please refer to Appendix D, the Medicare tip sheet on page 132 for more detail.

When filling out a SHIP form your name will automatically populate into the left hand corner of the form and the clients name will populate in to the Beneficiary name. Don't forget to scroll to the bottom of the page to save.

SHIP forms, once saved will show under '**Client's Saved Data Forms'** on the dashboard screen.

APPENDIX L

Documenting a Call

Family Caregiver Form

When filling out a Family Caregiver Form your name will automatically populate into the left hand corner of the form and the name of the CONTACT will populate in the fields for Name of Caregiver. The CLIENT person's name will populate in the Name of Care Recipient. The form will also populate the fields for age and gender if known. Don't forget to scroll to the bottom of the page to save.

Family Caregiver Forms, once saved will show under '**Client's Saved Data Forms'** on the dashboard screen. Refer to Appendix C on page 127 for more info.

Documenting a Call

Options Counseling Tool

No fields will auto-populate for the Options Counseling Tool. However the name of the client will appear at the top of the form. Once you have completed the tool, click on the Save button and the form will then appear on Tab 2, in the center section under Client's Saved Data Forms.

Documenting a Call

Follow Up

Follow up, in most cases will be required based on the nature of the contact. Click the **Follow-Up** choice on the top tool bar to bring you to the **Follow-Up** window.

(See section 4 Refer 7.5 policy and procedures for more guidance related to follow up.)

Indicate the '**Schedule Date**' and '**Schedule Time**' as well as '**Follow-up type**'. Leave yourself a '**Follow-Up Note**' to remind you what your plans are; do not assume that you will remember or that you will be the one to complete it. You can also enter multiple follow-ups for a client at this time if you know beforehand that you will have continuous contact with the client.

There are specific protocols for LTS Counselors related to the 'follow up' function. Please refer to Procedure 110 and 120 for additional guidance.

Please pay close attention to **"whom"** the follow up is for. Is it for the client or the caller?

Documenting a Call

Incomplete Call

See Procedure 100 for additional guidance

Incomplete Calls are calls that are interrupted for a short time. Per policy, calls will be entered at the time of the call. All other contacts will be completed in Refer7 within 2 business days of the contact. **The incomplete call function is not to be used to replace the Follow-Up.**

For example:
- You would incomplete a call that was initiated but needed to end due to client needing to call back because someone was knocking on their door.
- You would complete call and set up a follow up to call contact person in reference to materials you are sending them.

If at any time during a contact you need to stop and do something else, click the 'Incomplete' button. The Incomplete or Transfer Contact window will appear. In this window, you can choose to incomplete this contact to yourself or someone else. You also have the option of choosing 'Client' or 'Caller'. Making a contact incomplete stops the internal clock. Don't forget to 'Save'.

Note: If you have ended the actual contact with the client but continue to work on the case you can leave the call open so that the clock is still adding time, giving you credit for the total time spent on the call/event.

Documenting a Call

Incomplete Call

To return to an Incomplete Call double click the blue line from the **My Incomplete Calls** list and the call will automatically reopen and the internal clock will restart.

Save incomplete call brings you back to the dashboard screen.

Documenting a Call

Transfer Call

When you transfer a contact, to another office, you no longer have access to edit the contact. Ensure that you have completed all your notes before transferring. If you accomplished significant work, or spent significant time with the caller, complete the call as your own. Then start a new call with the caller and client, and transfer the new call to the other office, including a note to guide the other worker.

See Procedure 100 for additional guidance

Documenting a Call

End Contact

Clicking on '**End Contact**' Closes the contact and stops the internal clock.

There are 3 qualifying actions that will allow you to close a call
- Saving a Referral
- Saving an Unmet Need
- Saving a Reason for Call

Without completing one of these actions, you will not be able to end the contact.

Editing Referral Activity for Closed Calls

From **Previous calls,** you are able to edit referral activity. Highlight the call, by placing your curser on the blue line (call date and time) and click 'reopen' or 'edit'.

'Re-Open' starts the internal clock when making changes or corrections.
'Edit' gives you access to the call; however, the internal clock does not start.

Editing Referral Activity for Closed Calls

Contact Activity
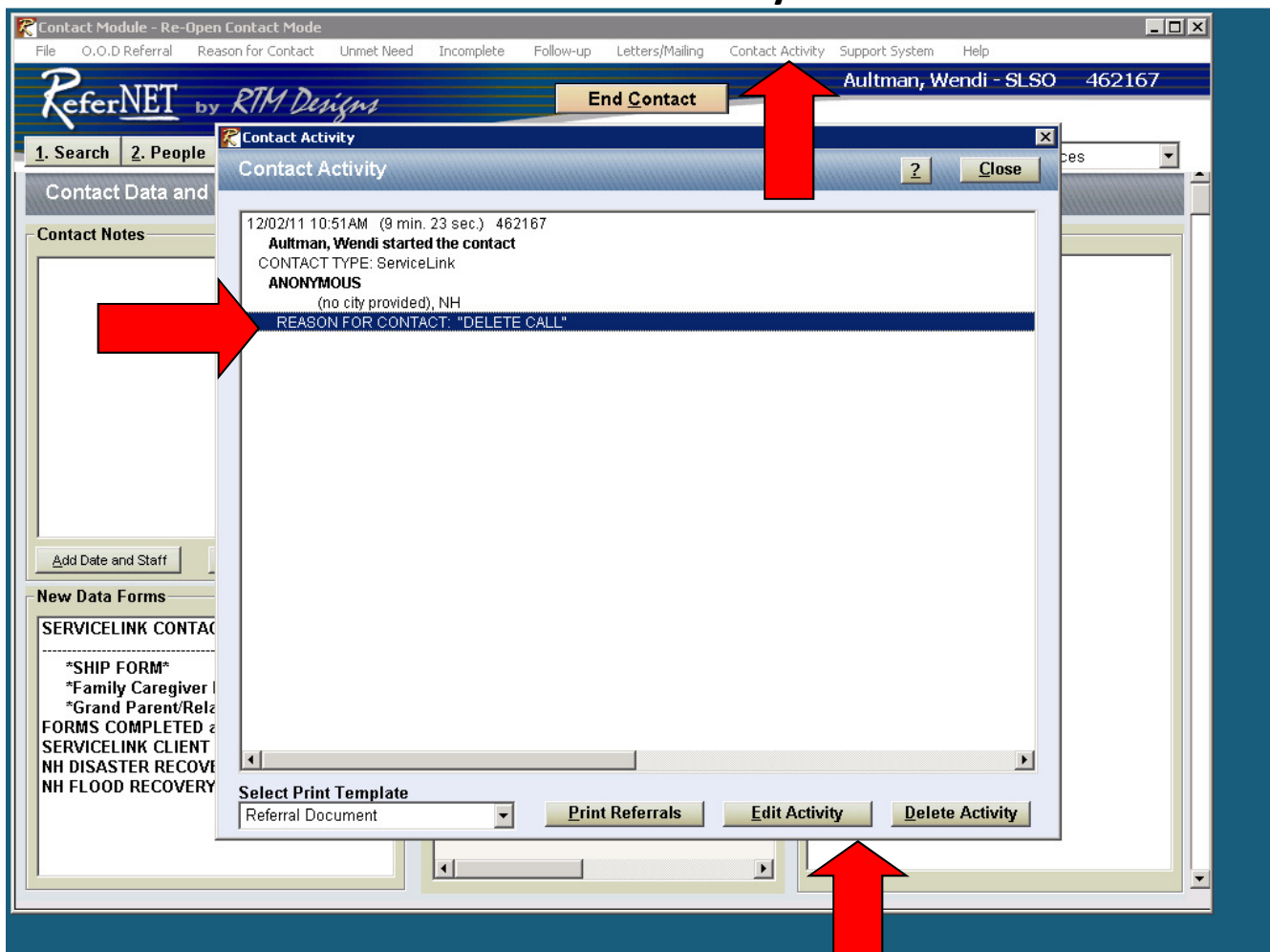
Click on 'Contact Activity'.

Place your cursor on the activity you intend to make changes. You have the option to 'Print Referrals', 'Edit Activity', or 'Delete Activity'.

On the **Call Activity** screen click the **Edit Activity** button to make changes. To delete the entire referral click the **Delete Activity** button. **Be very careful when using this!** You can also double click on the referral in the text box to edit an activity.

When you click the **Edit Activity** button it brings you to the **Edit Referral** screen. Referrals can be changed or deleted from this screen. When you are done you can **Close** the screen and exit the call.

An example of a reason to **edit** a referral may be if you are aware that an Agency or Program has had a change in their phone number but BEAS has not yet updated that Agency or Program in the **Resource Module** and you want the referral that you are giving the client right now to be accurate.

When you click the **Letters/Mailing** button from the **Call Module** it brings you to a Client Mailing window. From here you can select multiple mailings to go to an individual. Select the Recipient from the drop down menu and the name and address will populate for the individual selected. You can choose a **Cover Letter** to go with the mailing from this screen. A cover letter is recommended.

You can also view the mail history. This will alert you to past mailings to a caller or client.

Notice you also have the ability to 'edit' or 'delete' selected mailings.

Client Mailing

To access the mailing module go to the tools selection on your tool bar at the top. In the **Client Mailing** you can see and print mailings that you previously marked. Make sure that you are using the correct date range (**From** and **To**) and click **Display**. All un-mailed mailings will appear in the **Mailing List**. When an individual name is highlighted on the **Mailing List** the **Cover Letter and Printed Material** box will populate. The **Mailing List** tells you what Refer7 will print out for you and the **Cover Letter and Printed Materials** section shows you what you need to put with that cover letter.

Client Mailing and Exporting
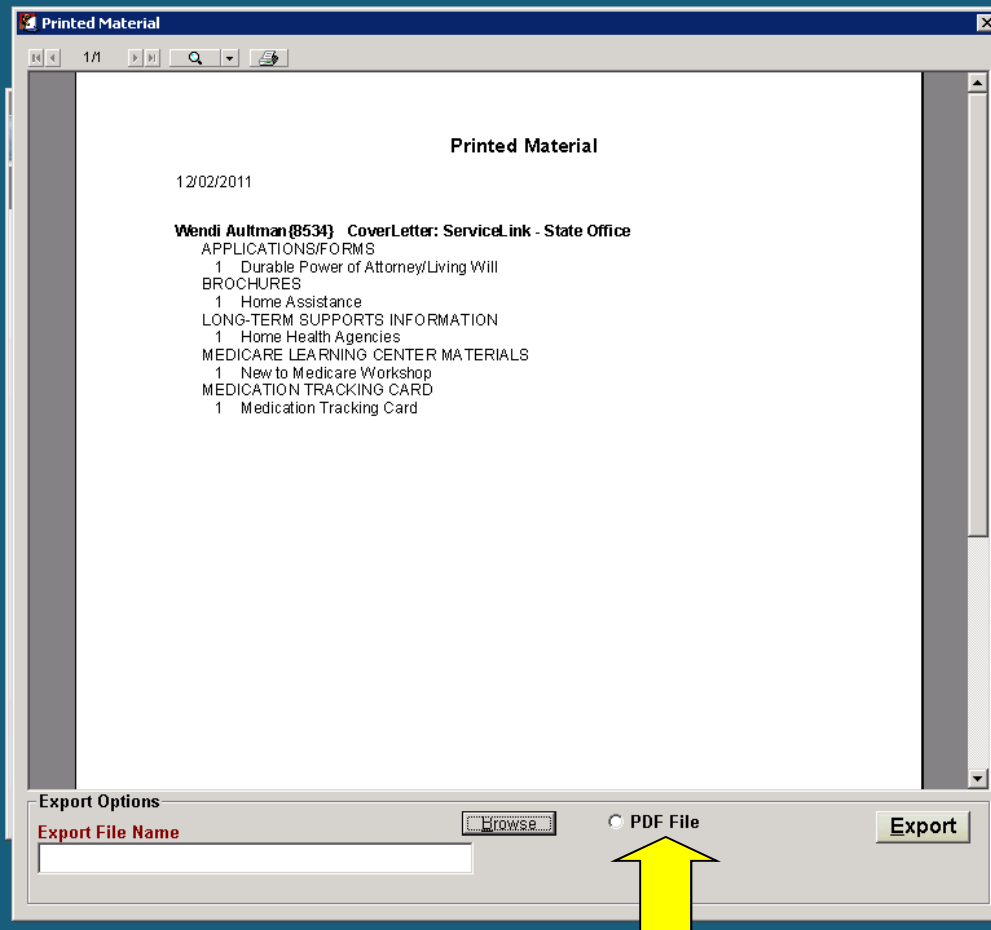
From the **Mailing Module** you can **Print** a list of the selected material, **Preview** the cover letter generated by the system, the list of materials to be included in the packet, and print **Mailing Labels**.

*Note, when selecting preview the system first populates the cover letter. Close out of this box and the preview list populates.

When print function is launched in call module, you will have the opportunity to **Export to PDF.** By exporting a document whether it by a referral activity list, notes history, or a cover letter, you are able to retrieve this document and save it to your computer for your records or to email to someone. It can also be retrieved and then uploaded to e-studio.

Client Mailing and Exporting continued

Click export and like "magic", your file will be sent to RTMs website for you to retrieve.

Go To: http://www.rtmfiledownload.net/

A list of your exported documents will display and by right clicking on your mouse you can save the file to your computer. You can also delete.
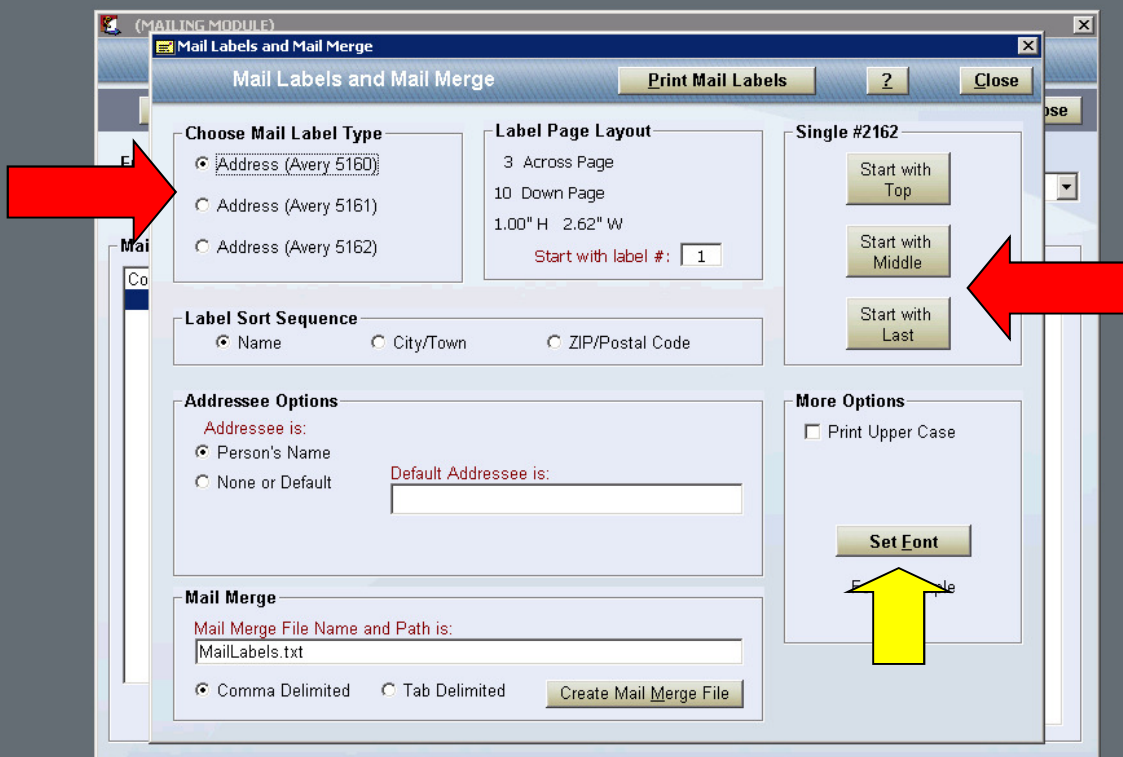
To print **Mail Labels** for one or multiple individuals click the **Mail Label & Merge** button and this screen will appear. This screen allows you to choose the size of the address labels that you want as well as the page alignment (used for ½ or ¾ labels sheets so they can be re-used). Click the **Do Mail Labels** button when you are ready to print out the labels of all highlighted names on the previous screen. **Mail Merging** is saving the address labels to a file; you will probably not need to do this.

When doing labels you can decide where on the label page you want to start by changing the **Start with Label** box above. The basic Avery Label 3 row sheet is set up like the table above. You can also change the **Font** of your labels.

Create or edit a cover letter

To create or edit a cover letter scroll to the bottom of the **Select to Edit or Create a Cover Letter** drop down box and choose either:

1. **New Letter; or**
2. **Existing letters that you want/need to edit.**

Create or edit a cover letter

When creating a new letter choose the **New Letter** option on the previous page. You will need to name the **Cover Letter** as well as write the body of the text that you want in the middle text box.

Create or edit a cover letter

The consumer's name and address will automatically populate. In the bottom box you will write ServiceLink of XXX County and the address, which will automatically print out at the bottom of the letter every time it is printed. **Checking the Print Staff Person's Name** box will automatically print the person who is actually printing the cover letters name out above the ServiceLink of XXX and address without you typing it in manually. If you are going to have a volunteer print out mailings for your office and you do not want the volunteers name being printed on the cover letters you will not check the **Print Staff Person's Name** box you will need to type the appropriate staff person's name in the bottom box above the ServiceLink of XXX County line.
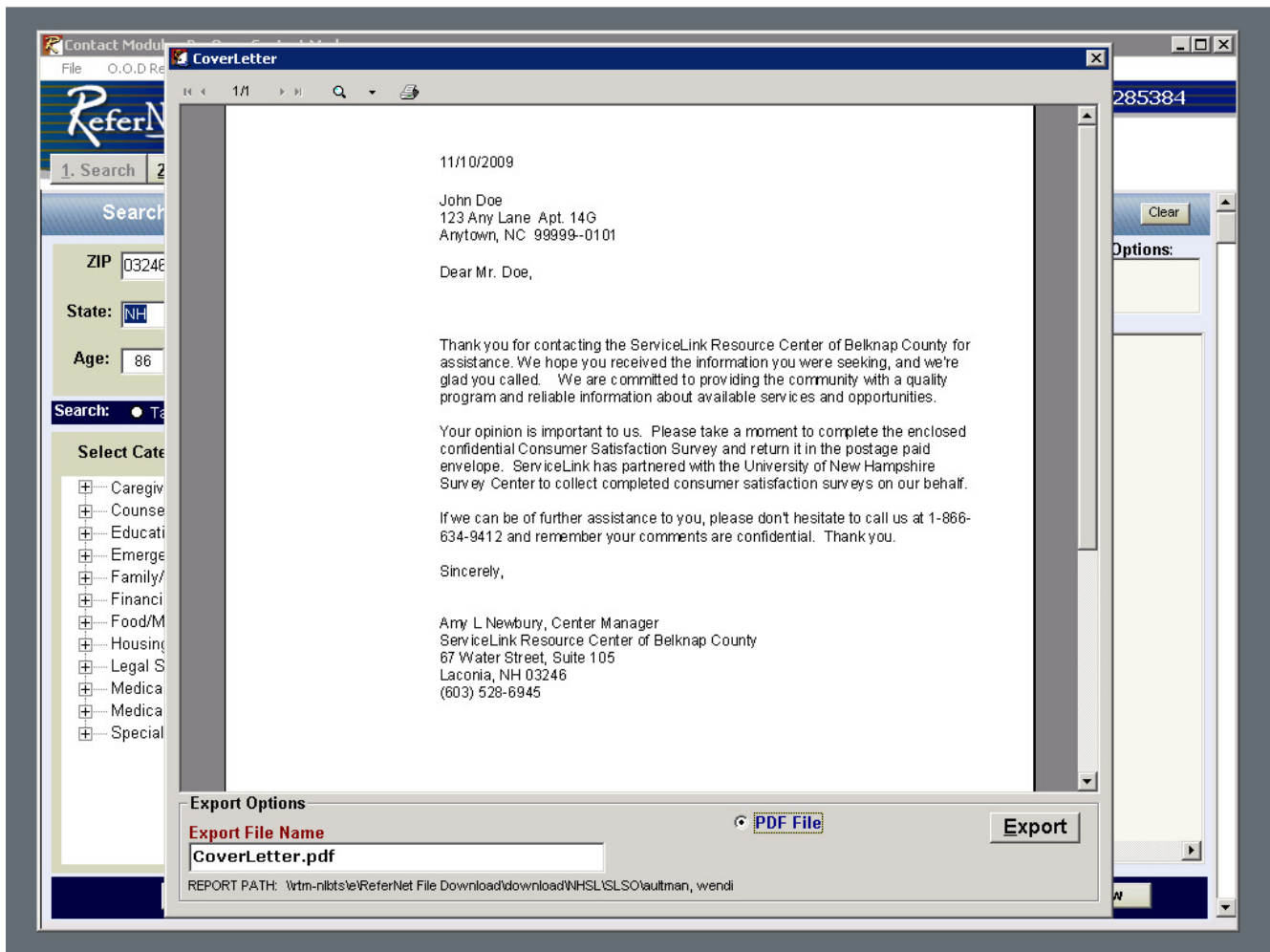
Cover Letters

Above is an example of the mock cover letter and the preview of what the printed version will look like.

TIPS:
- The cover letters have been positioned to fit all SL/SLRC Cover Letters. If you find that your SL/SLRC cover letters are not printing correctly notify BEAS.

- Copy and paste your text into a Word Document. In order to set the grade level you will have to make sure that there is at least one spelling error. I have intentionally spelled the first word in this document wrong.

- Select tools on your Word menu and click **Spelling and Grammar**.

- At the box above click the **Options** button.

- Put a checkbox in the **Show readability statistics** box and click **OK.**
- Once spell checking has been completed the Readability Statistics box will appear and give the Grade Level of the document.

- Whenever possible, try to keep your letters close to an 8th grade reading level.

ESCAPE CALL

There are times when you may start and contact and OOOPSSSS! I didn't mean to do that!!!

You can close the call out without affecting stats by utilizing the ESCAPE CALL feature. This option should only be used when a legitimate mistake has been made. By utilizing the ESCAPE CALL, all information for that contact will be lost (and therefore will not affect stats). This includes any data forms, referrals, client info and contact data. The only The Refer7 System Administrator frequently goes in and reviews these and will batch delete them as needed.

Reports that get pulled on the frequency of this are periodically sent to Center Managers.

It is the responsibility of Center Managers to maintain this by batch deleting escape calls at least **MONTHLY**.

MAINTAINING DELETE CALLS

Center Manager can maintain Delete Calls by doing the following:

1. Go to previous calls for your office
2. Choose the time period you want to search
3. Choose ESCAPE CALL
4. Click on Find

Once the previous contacts are populated you can review, print list for review later and can begin the process of batch delete.

STOP   CAUTION: Be sure that all there is showing are ESCAPE CALL contacts before deleting.\

MAINTAINING DELETE CALLS

Batch Delete function
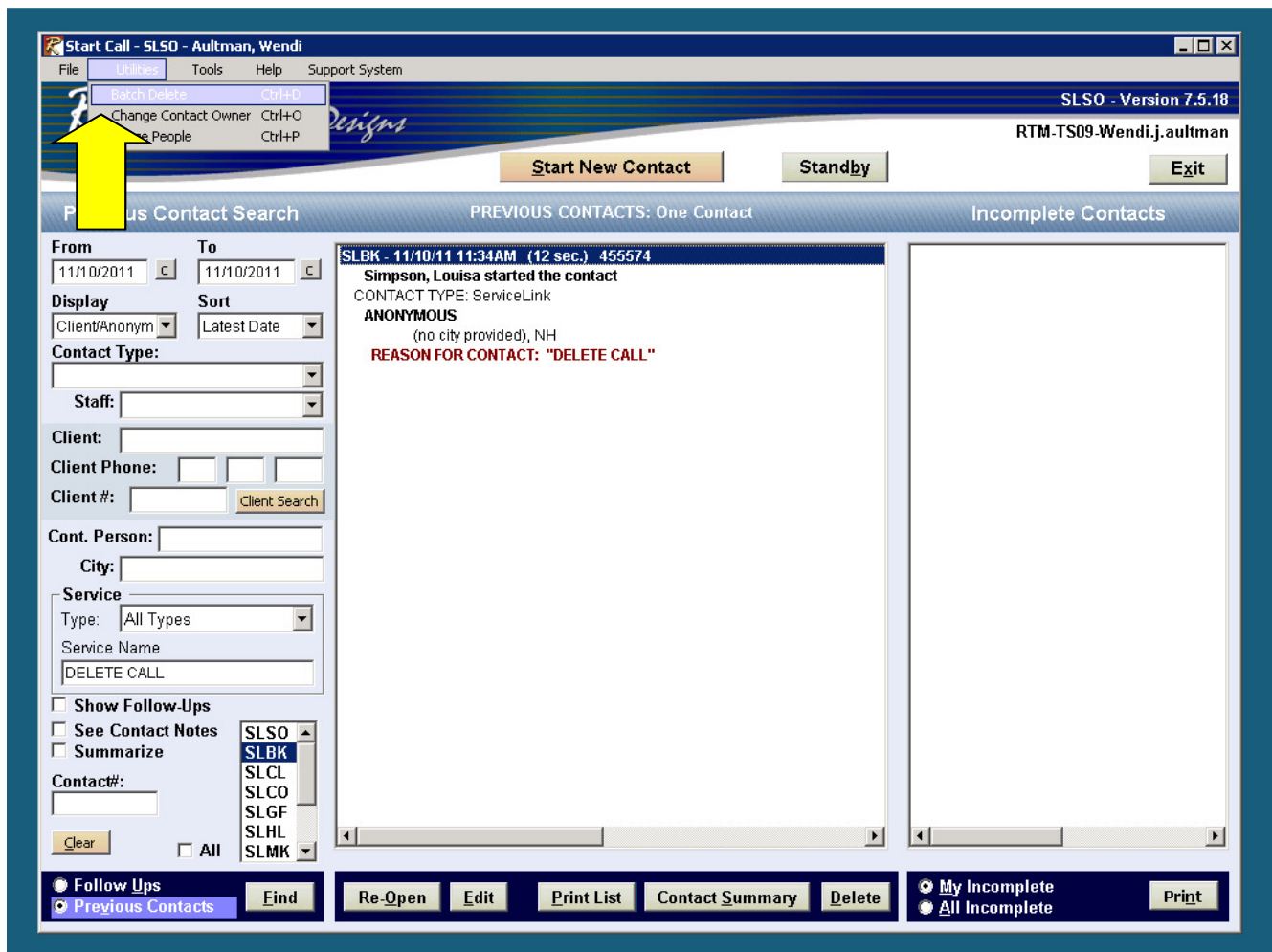
Go to utilities at the top of your screen and choose batch delete.

The system will ask:
"do you want to delete the xx displayed contacts?"
say YES

The system will ask:
"ARE YOU SURE?"

If you are sure, say YES.

You are done.

SUPPORT SYSTEM

REFER 7 TRAINING
Searching and Making Referrals

Version 3.03.0

What is AIRS and Taxonomy?
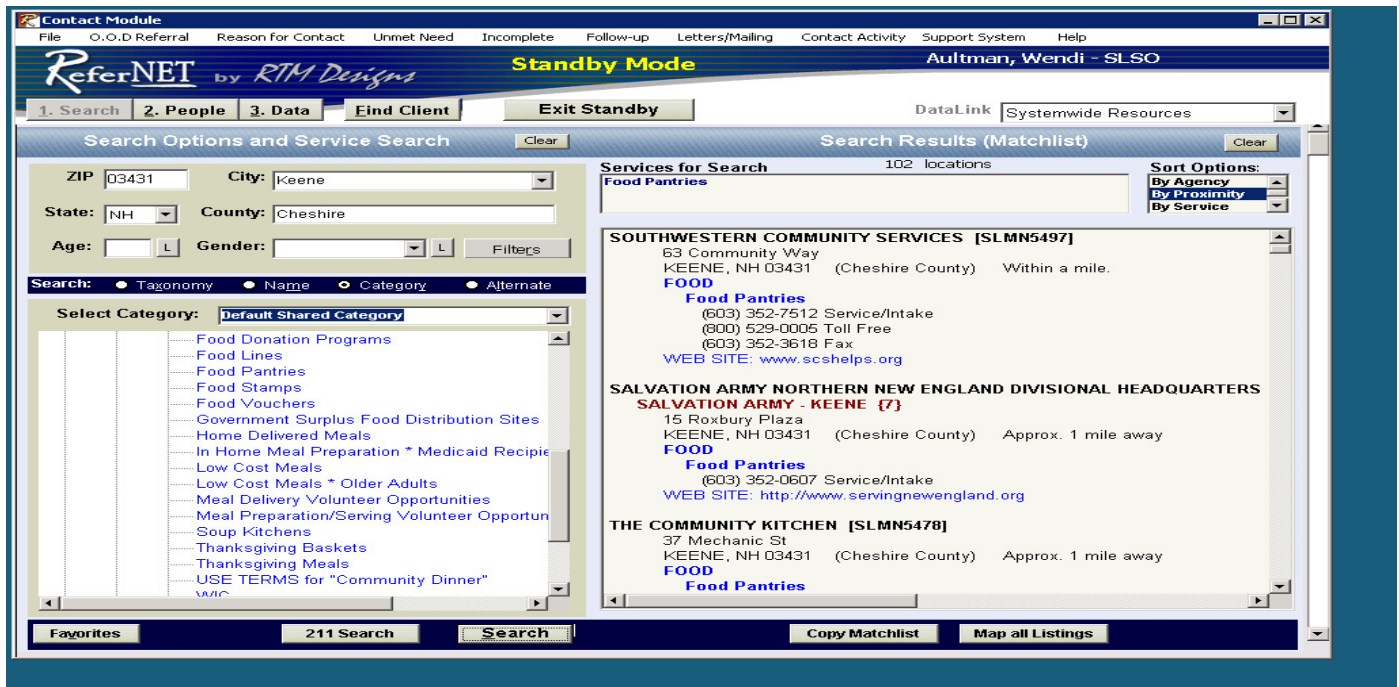
AIRS stands for the Alliance for Information and Referral:

What is AIRS?

The Alliance of Information and Referral Systems (AIRS) improves access to services for all people through quality information and referral.

AIRS provides a professional umbrella for all I&R providers in both public and private organizations. Comprehensive and specialized I&R programs help people in every community and operate as a critical component of the health and human service delivery system.

The Mission of AIRS is: "To provide leadership and support to its members and Affiliates to advance the capacity of a Standards-driven Information and Referral industry that brings people and services together."

For more information about airs look at your offices ABC's of I&R training Manual.

Taxonomy is the distinguishing ordering and naming of groups within a specific subject field classification. It is used to organize agency and site services.

There are six levels of taxonomy, each becoming more specific than the last.

EXAMPLE:
Health Care is a Level 1 taxonomy term;
Health Supportive Services is a Level 2 taxonomy term because it is a more specific than "Consumer Services";
Assistive Technology Equipment is a Level 3 taxonomy term;

Mobility Aids is a Level 4 taxonomy term;
Automobile/Van Adaptations is a Level 5 taxonomy term.
Adapted Vehicles is a Level 6 taxonomy term.

The goal of taxonomy is to accurately identify the resource in a standardized way and to bridge the gap between being too broad in scope; and having too many choices to wade through; and being too narrow in scope and missing all available resources.
Level 6 terms are by far the most specific and as such aren't used very often. They are fairly new and there aren't very many services that actually get to that level. On the other hand, most level 1 and 2 terms are entirely too broad to hold any meaning to the I&R Specialist, as a result, most services are coded at the level 3, 4, or 5 of the overall tree.

Under AIRS standards, only one level should be used for a service and once a level has been chosen it must be used across the database. Using the example above, if a resource is coded as Mobility Aids at level 3, the level 4, 5, and 6 cannot be used anywhere in the database for any other service or agency.

The **Use Terms** will point you to the term used in the ServiceLink Taxonomy. AIRS standards are available for you to view on the AIRS website at the following address: http://www.airs.org/i4a/pages/index.cfm?pageid=1

Search Page

Searching using taxonomy

Enter the taxonomy term or service that you are searching for into the first empty text box. You can either hit enter or the **GO** button to the right. A list will fill the middle text box with additional choices to assist you in narrowing your search. Scroll through this list until you find the taxonomy term that is most appropriate.

211 Search button displays local 211 offices and can display 211 programs nationally.

Favorites displays top 20 service and name searches for your office

Identify zip code or city to narrow search

Search Page

If you are not sure what it means or if it is the correct one, click the **Service Definition** button. Until you become more familiar with taxonomy it is expected that you will check multiple definitions before finding the most appropriate taxonomy term for the service that you are looking for.

Tip: If you un-click the options box it will clean up your taxonomy search box, however this box provide you with a display of additional taxonomy terms options from the virtual use and see also function.

SEARCH PAGE
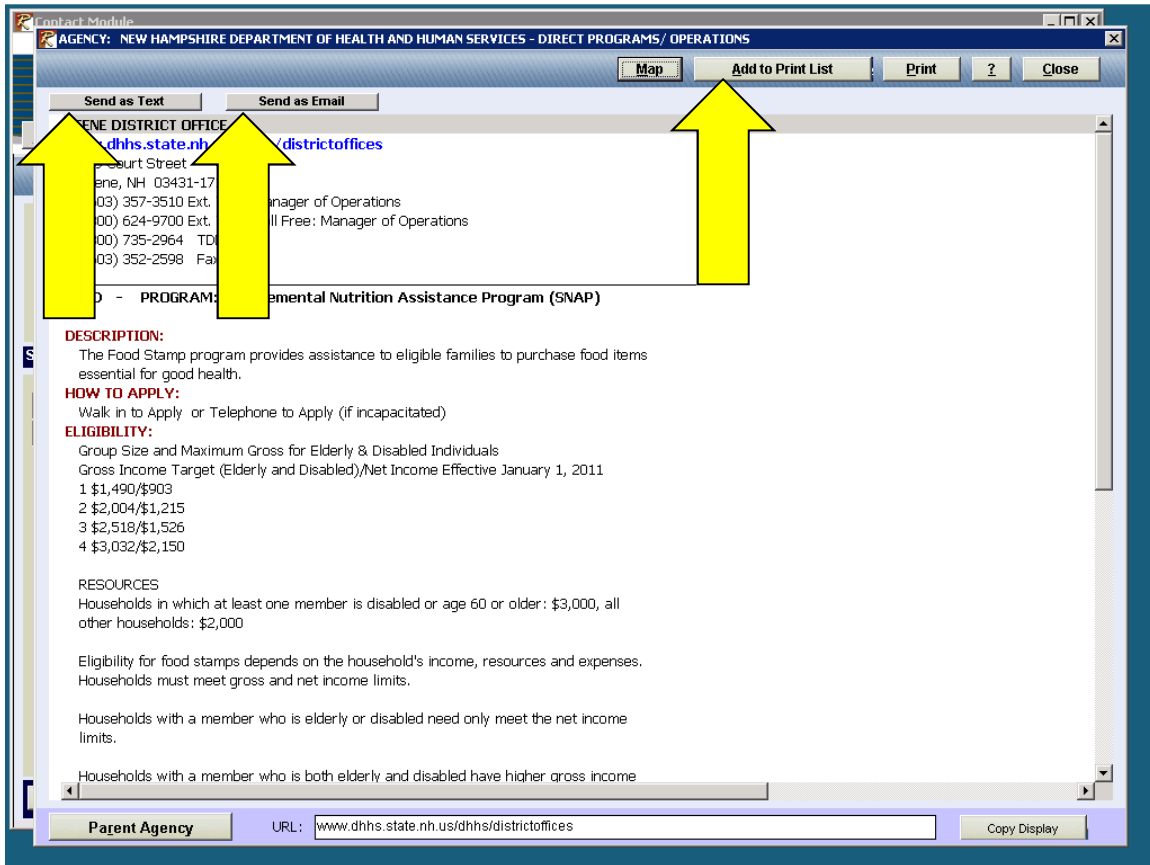
Staffs can now email and text information about agencies, sites, and services. See the next page for more detail.

When you click the **Search** button, the **Matchlist** will appear. The resources are listed in alphabetical order because there wasn't a zip code on the previous screen. If a zip code has been entered into the call screens the **Matchlist** will be in order of proximity and then sorted alphabetically, starting with the resources closest to that zip code.   When you highlight a choice (any line) the Service Information will appear.

Click the **Add to Print List** button to add the resource the list that you are building for a client. To save service or the agency as a referral, highlight that line and click the **Save Referral** button. Per policy you must refer consumers to all available resources and options based on consumer request.

Emailing and Texting information

For texting, you will need to acquire the cell phone carrier of the person you will be texting the information to, phone number and return email. You can text several referrals or one service at a time.

For email you can set up and email template: Contact Administrator to do this. You can choose to include or not include the referral information automatically. Remember to spell check and double check your referral list before send

ing.

SEARCH PAGE

Once a referral has been saved, you can view them by clicking the 'View Referral List' button at the bottom right. A referral print box will appear, displaying referrals made.

Notice the {R} represents a saved referral

SEARCH PAGE

The **Referral and Matchlist Print** section to the right of the page offers a few other options. You can print a list of all saved referrals by clicking on the Preview then **PRINT** button. You call also add all agencies at one time by clicking the **Add All Agencies** button. Be careful when doing this, it will add all available agencies, regardless of proximity, in some cases it could be a lengthy list. Refer7 has a **Disclaimer** that is automatically added to the bottom of every page printed from the Matchlist.

Double Click on the blue terms to view additional information about the service provided by an Agency and any details that the system has. The details of the services offered will give you site hours, program/service descriptions, fees, and other things.

Favorites
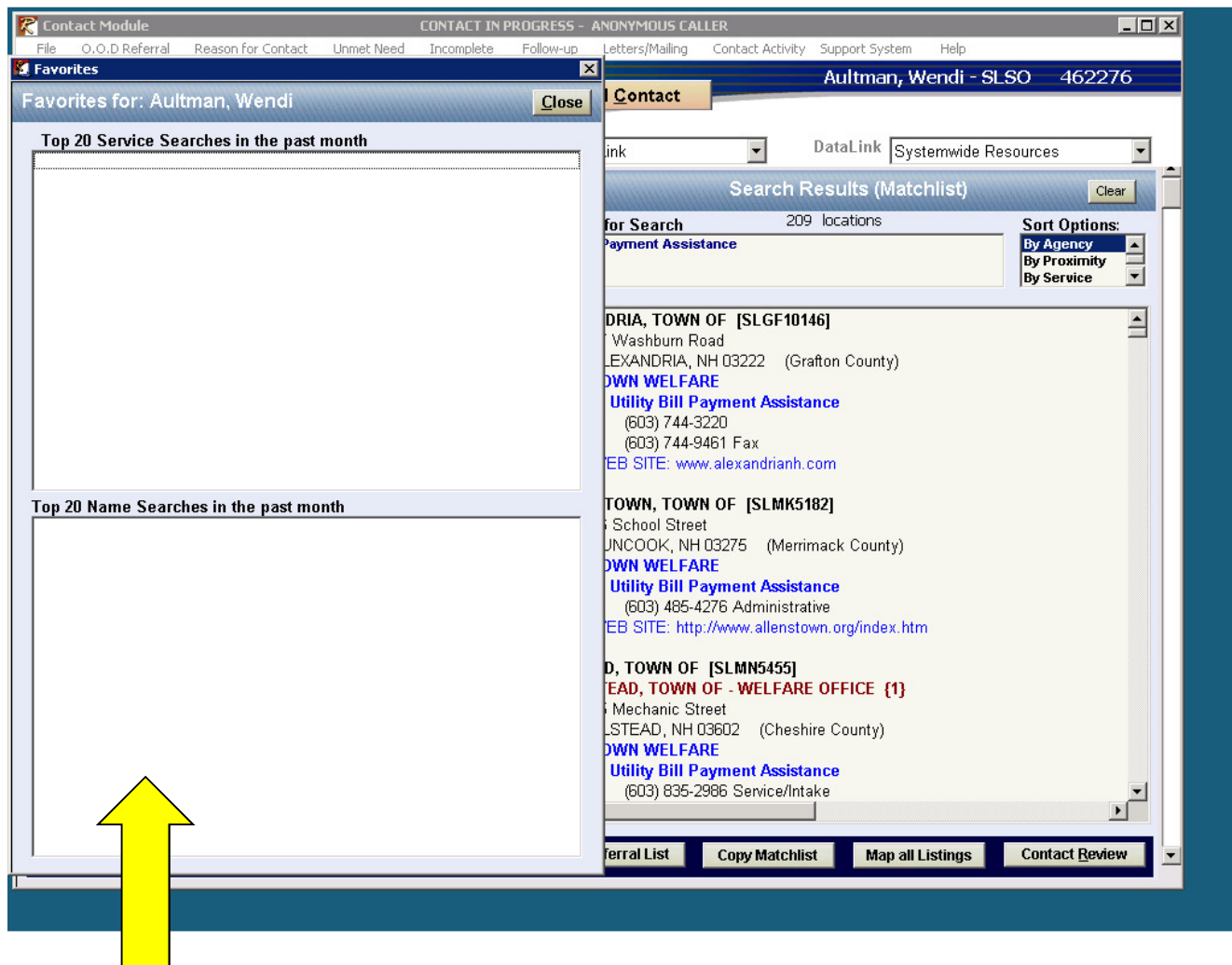
A favorites button will appear once you have started initiating searches and making referrals. At this time, "Favorites" displays your SLRC Offices top 20 taxonomy and name searches.

SEARCH PAGE

Searching by Category

Note: **Searching using ALTERNATE TERMS** ****Not Used****

BEAS has decided to not use alternate terms in the Resource Database. BEAS is customizing the taxonomy to make searching easier.

CATEGORY searching can provide a short cut.

Searching using NAME

After typing in the name of the Agency or Site that you are looking for, click the **Search** button. If the Agency or Site comes back as unknown you **always** try to reduce the **Name** of the Agency or Site. For example, if you type in Granite State Independent Living and the Agency comes back as unknown try changing the **Name** to Granite State, and so on. The **Search Screens** will not find something if it is spelled incorrectly or if the punctuation in the Agency or Site typed is different from what is in the system.

For Example- Belknap – Merrimack CAP Service Link

The % symbol can be used as a wild card when searching for anything in Refer and make it quicker to locate exactly what you are looking for. In the example of Belknap – Merrimack CAP you could type in Belk%CAP and retrieve the same result. The trick is to use enough letters to narrow your search sufficiently while not having to type the entire word. The % symbol can be used for searching by name, taxonomy and even a client name search.

<u>SEARCH PAGE</u>

Out of Database (OOD)

If the Agency or Site providing the service that you are searching for is not in Refer7 an **Out of Database (OOD)** referral can be done. All possible steps for searching for an Agency/Site/Service must be taken before doing an **OOD** referral. Most large Agencies are in the system even if some taxonomy and service groups have not been attached. Searching using the Agency or Site name will be necessary. When using the **OOD Referral Screen** complete all sections for data

collection accuracy. When entering an Agency or Site check your spelling and do not use acronyms.

If an Agency/Site that should be in the database is not you must contact your offices database specialist or the BEAS system administrator so that steps can be taken to request that the agency add their information.

Many Agencies are not appropriate for inclusion in our database. If an agency is only referred to rarely or does not meet the Inclusion/Exclusion policy standards BEAS will not add it even if requested by a ServiceLink staff member.

**See Refer7 Inclusion/Exclusion policy for more details.

APPENDIX L

REFER 7.5 SCENARIO
Training Module

APPENDIX L

Scenarios created by the Information and Referral specialist workgroup

Instructions

Each individual completing 2 full days of Refer 7.5 training must enter in contacts based on the eight scenarios created by staff.

<mark>Scenarios must be entered into the training system not the LIVE system. Please contact your system administrator if you have questions about this.</mark>

If individuals are located in the client database and the scenario says they are new please treat them as new.

Once a trainee has completed logging in all scenarios utilizing the skills, modeling, and manual provided to them they will:

1. Notify Direct Supervisor and/or SLRC Refer7 system Administrator by email that you have completed the task. You should complete all scenarios within 1 to 2 weeks of getting training.
2. Direct Supervisor and or the System Administrator will then review the work and provide feedback to the trainee.
3. Feedback will consist of highlighting accurate work and identifying challenges that need to be modeled more, coached on over time, and reviewed by going to the manual and policies.

REMEMBER:

- Put into practice what is learned through face-to-face training and instruction, observation and modeling at the SLRC office, as well as the manual.

- It is ok if it is not perfect. That is part of learning.

Training Scenario #1

The phone rings and a man by the name of Todd Johnson is on the phone. He is from Massachusetts, but his Grandmother, Suzy Johnson, lives in Belknap County. Todd is concerned that his grandmother is not taking care of herself. He thinks that her house could use some regular cleaning and maybe she could use some personal care, such as help washing her hair or even doing laundry.

Suzy is 87 years old and lives on her own. She can't always hear the phone because she does not like to wear her hearing aids in the house.

Todd has not called ServiceLink before and does not think his Grandmother has either. Todd would like some information and would like to come and talk to you about all the options in a follow-up appointment next week.

Todd's information
Cell phone 603-555-1111
67 Water St, Lowell MA 01852

Suzy's Information
603-524-0000
17 Landing Lane, Laconia, NH 03246
Monthly income $557
Older Adult
DOB 12/4/1922

Todd is free next Thursday at 1pm to meet with you and believes he should get the information you will send him by then.

Associate Todd with Suzy.

In addition:
- It appears that you forgot to start the call when you first started talking to Todd. Add 10 minutes to the call.
- Text Todd the information (use your cell phone as the test)

Screen Shots to Follow

"The phone rings and a man by the name of Todd Johnson is on the phone"

Todd is the Contact Person.

Search for Todd Johnson.

Select 'Add New' as Todd Johnson has not had previous contact with SL.

APPENDIX L

Todd's information
603-555-1111
67 Water St, Lowell MA 01852

Select 'Save' to save contact information.

12/1/1512/1/15Search and Referrals Module   Version 3.0 **Refer Training**   81

Page 86 of 193

Todd has identified himself, as the grandson to the client, therefore, 'contact person type' is Friend/Relative.

APPENDIX L

Search for client

Suzy Johnson's Information
603-524-0000
17 Landing Lane, Laconia, NH 03246
DOB 12/4/1922

Select 'Add New' as this search revealed no one matching Suzy's identifying information.

Suzy Johnson's Information
603-524-0000
17 Landing Lane, Laconia, NH 03246
Monthly income $557
Older Adult
DOB 12/4/1922

'Client Type': Suzy is an older adult
Medicare Number: not provided
Race/Ethnicity: not provided
Married
Client Marker: does not apply in this case.

Enter all information and Click Save.

Page 2.People

Suzy is identified on the left hand side of the screen as client and Todd on the right as the identified contact.

Todd now is to be associated with Suzy. Click on 'Add' to make the association and choose the relationship.

Page 3 Data

Contact Marker: A telephone call; therefore, 'Call' box is checked.

This is Todd's first time calling ServiceLink.

1.Search Page

Search for resources to meet the needs of the client.

2.people

Click on 'Client Activity and Notes'

APPENDIX L

Schedule a follow up for next Thursday at 1:00pm.

'End Contact' closes the call.

Click on 'client activity and notes' and then review to add time to your contact.

Also, it appears that you forgot to start the call when you first started talking to Todd. Add 10 minutes to the call.

2.People
Activity and Notes
Review

Please move on to the next scenario….

APPENDIX L

At the desecration of the Refer7 trainer in each office, these scenarios can change.

The following are examples of scenarios that can be used.

Training Scenario #2

An African American male walks in. His name is Elmer Fudd, he is 35 years old, and he states he is disabled, homeless, and hungry and has no money. He is a low level reader and can only write his name. He has never asked for help before. He is couch hopping at this time. He has no medical doctor at this time.

Elmer's message phone is at Daffy Ducks house at 603 999 9999. Daffy also is allowing him to receive his mail there at 99 West Street, Rochester, NH 03867.

You give him the number to the Strafford County Homeless Coordinator at local Community Action office. He used our phone to call.

He called My Friend's Place Homeless shelter, they had opening, gave him bus tickets to get there today.
Gave him soup kitchen and food pantry listing, verbally told him the days/times locally

He wants to apply for Medicaid, food stamps and Social Security disability.

Gave him homeless medical van schedule in Strafford County

Associate Elmer and Daffy

Enter all referrals into system

Set up follow up office visit for later this week with I and R specialist for help with DHHS application and Social Security application..

APPENDIX L

Training Scenario #3

The Phone rings! It is Sarah Old calling for her husband David Old. David will be turning 65 in 3 months. Sarah wants some information on Medicare. She is very confused. Sarah indicates that she has read the *Medicare and You* book and is still confused; Sarah found our number on the back of the *Medicare and You* book.

Sarah provided the following information:

Their Physical Address is: 156 Depot Rd Tamworth, NH 03886
Their Mailing address is: P.O. Box 123 West Ossipee, NH 03890
Their Phone number is 603-323-4321

David's SS income is $1,104

Sarah's SS income is $523

David is a Veteran.

Associate Sarah to David.

David is White

David's Dated of Birth is 08/31/1944

Additionally, schedule an office visit for next Tuesday at 10:00 and document a note as to your

actions.

APPENDIX L

Training Scenario #4

The phone rings! Nicole Sunny of 246 Fenway Avenue, Gorham is calling regarding some Veteran papers and forms that she received in the mail on her husband, which has now passed away. Client is very nervous because she is not sure what to do with the papers. This is Nicole's first time calling ServiceLink Resource Center. A neighbor told the client about ServiceLink.

Nicole provides you with the following information:

Nicole's physical and mailing address: 246 Fenway Avenue, Gorham, NH 03581
Telephone number: 603-466-7878
Nicole's Date of Birth 07/14/1920 age: 89
Nicole is white
Nicole is home bound

During the conversation with the client, I scheduled a home visit for 07/22/2009.

Provide referrals for assistance on forms.

Schedule a follow up to indicate a home visit with client.

APPENDIX L

Training Scenario #5

The phone rings! Pete Test of 20 Main Street, Nashua is calling regarding his sister Cindy Test,

also of Nashua. Pete is concerned about Cindy's high heating costs. Pete is looking for options

for heating assistance. This is Pete's first time calling ServiceLink. A friend told him about SL.

Pete provides for you the following information:

Pete's physical and mailing address: 20 Main Street, Nashua

Telephone number: 603-555-1234

Cindy's physical address: 40 South Street, Nashua

Cindy's mailing address: PO Box 10, Nashua

Cindy does not have a telephone

Cindy's total monthly income is 666.00

Associate Pete to Cindy.

Cindy is a "hard to reach" client

APPENDIX L

Cindy is disabled.

Cindy is Asian.

Her Date of Birth is 12/29/1930

Additionally, schedule a follow up for one week, send a consumer satisfaction survey and

document a note as to your actions.

Training Scenario #6

The phone rings. Daisy Sunshine of 241 Meadow Rd in Claremont is calling to request a ride to her daily dialysis appointments in Lebanon, NH. Daisy needs to receive dialysis treatments Monday thru Friday at 10 am each day. Daisy does not drive and has no friends or family available to help her. This is Daisy's first time calling – she was referred by her doctor. Daisy does not have Medicaid insurance.

Daisy provided the following information:

Physical and mailing address: 241 Meadow Rd – Claremont, NH 03743
Telephone number: 603-555-1000
Daisy's monthly income: 661.00

Daisy is disabled
Daisy's DOB: 01/01/27

Search for "transportation"
Will need to document an "unmet need"

Additionally – send a consumer satisfaction survey and document a note to your actions of this call.

APPENDIX L

Training Scenario #7

Your 8:00 appointment, Mary Test, has arrived. She works for city welfare and has called you in the past, on behalf of clients. On the way to work today she wants to get information from you that will help her in her role as caregiver to her husband, George Test.

George is 63 years old and recently diagnosed with middle stage dementia, about which she would like more information. He has an honorable discharged from the Marines after a year in Vietnam, due to PTSD.

Mary wants George to stay at home with her and does not want him to go into a nursing home. She and her husband have no legal documents, such as a Health Care Durable Power of Attorney or Living Will drawn up yet, so she wants to find out about becoming his guardian. She does not have much savings to pay for it.

Their home address is in Pittsfield, but they get their mail sent to P.O. Box 38 in Center Barnstead. Mary does not want to get any phone calls at home or at work, but her e-mail address is : MaryTest@aol.com.

APPENDIX L

Training Scenario #8

An elderly gentleman walks into the ServiceLink office looking for some assistance. He is

looking for help with his property tax bill. He heard from a friend that he might be able to get

abatements from his city and the state. His friend also told him to come to the ServiceLink

office for information and help with filling out the forms. He had never heard of ServiceLink

before his friend telling him about the help that we could provide him with forms.

The gentleman gives his name as:

Jack White

His physical and mailing address are 17 Allds Street, Nashua 03060

Jack's phone numbers are: 603-595-0000 - home and cell phone 603-860-4000

Jack's monthly income is: $1200

His date of birth is 1/1/1931

He is widowed.

Jack states that money is getting harder to stretch these days and does not know what he will

do this winter if it is very cold. He has been able to make payment arrangements with the

utilities so far, but does not think he will be able to do that next year. The cost of food has risen

with everything else and he has been put on more medications this past year too, and even

though he does have a Part D plan his premiums and co-pays put another dent in his shrinking

income.

Provide information and referral to local and state agencies that provide tax abatements

Offer other referrals to help alleviate some of the financial burdens that Jack has been experiencing.

Schedule a follow up in one week to see if Jack has gotten the information and paperwork that, he needs to file for tax abatements and offer to assist with forms if needed.

REFER 7 TRAINING
Policy and Procedure

APPENDIX L

ServiceLink Policy and Procedure	
Policy Name:	Refer 7 System Contact Module Policies and Procedures

Section: 500
Initial Approve Date: 7/1/05
Last Approve Date: 12/1/1512/1/15
Written by: ServiceLink Network
Last Draft Date: 12/1/1512/1/15

Policy 505: All of the ServiceLink Resource Center (SLRC) staff and volunteers will sign a ServiceLink Refer7 System User Confidentiality Agreement and initial on an annual basis. (See Attached)

- **Procedure:** Each SLRC Center Manger will assure that staff and volunteers using the Refer7 system have signed a Refer7 System User Agreement upon hire, and initial there Agreement every year thereafter.
- **Procedure:** The Bureau of Elderly and Adult Services will maintain a file consisting of copies of signed agreements prior to authorizing a username and password to a new hire to the SLRC Network.
- **Procedure:** Under no circumstances will staff be permitted to use the Refer7 system under another staff person username and password.

Policy 510: The SLRC Database will operate under the Alliance for Information and Referral System's (AIRS) standardized definitions for the use of Information and Referral/Assistance and education.

Policy 515: SLRC will operate free of bias or conflict of interest and make referrals in an impartial manner and in the best interest of the person contacting the SLRC. The SLRC will not discriminate based on race, religion, and place of origin, age, disability, gender, or sexual orientation.

- **Procedure:** SLRC staff will provide person contacting the SLRCs with **all** available resources and options based on person contacting the SLRC request. A minimum of **three** referrals shall be given when available.

- **Procedure:** When the procedure above is not followed the SLRC staff person/volunteer is required to document why in client notes.

- **Procedure:** When staff is not giving **all** available resources, staffs are required to rotate Agencies getting referrals so that referrals are not always given to the first three which appear in Refer 7. This also applies to all community (informal) resources logged in as an OOD referral.

Policy 520: The SLRC staff will at all times check by all possible methods to search for a contact/client's existence in the Refer7 database before saving them as a new person. Staff can refer to the Refer7.5 training manual starting on pg. 17 for more detail.

Policy 521: The SLRC staff person will record reasons for call and referrals based on glossary definitions provided by AIRS and the Bureau of Elderly and Adult Services in partnership with ServiceLink.

Policy 525: Contacts entered into Refer 7 will have a client. The client can be the contact person if the individual is calling about either himself or herself or the client can be another individual if the contact is calling about someone other than himself or herself.

Policy 530: The ServiceLink Contact Form will be completed on a minimum of all contact persons who were not previously in the system.

Policy 540: All calls will be entered at the time of the call. All other types of contact will be entered and completed in Refer7 within two business days of the contact.

Policy 545: All SLRC offices will follow Procedure 100 when a contact is out of state or an unrecognized exchange, or when a call is to be transferred to a team member in their own office or another office.

Policy 550: The SLRC staff, at a minimum, will enter the specified amount of data required in order to complete a contact.

- **Procedure:** The minimum required data to be entered into Refer7 for every contact is: zip code or contact name, contact type, contact marker, and client type. An action (reason for call/referral/unmet need) must be identified and recorded.
- **Procedure:** If the minimum required data to be entered cannot be acquired, the SLRC will use the Quick Call function in Refer7 to complete the contact.

Policy 555: SLRC staff will always enter in all pertinent addresses for a client if known.

- **Procedure:** For example: if the client has a mailing address, that address would be the address on the left part of the Refer 7.5 screen and their permanent residence address will be address to the right of the Refer7.5 screen.
- **Procedure:** Staff will enter temporary residence in client notes.

Policy 560: Under no circumstances will ServiceLink Resource Center staff type into **ANY** drop down box.

- **Procedure:** Refer 7 users will choose only from the choices listed in that drop down. Staff can contact the System Administrators if they need any additions or changes to the choices that are already there. The System Administrator reserves the right to add or not.

Policy 565: When appropriate, staff will complete Client forms pertaining to the client using ServiceLink Resource Center services. This includes the SHIP form as well as other forms made available to staff.

Policy 570: SLRC Staff will use the follow up function to accurately reflect the work being provided by the SLRC.

- **Procedure:** SLRC staff will use follow up to schedule call backs to contact person for the purpose of:
    a. Determining the quality of the service the program delivered to the person contacting the SLRC;

    b. Ensuring the program is meeting its purposes and goals;

    c. Generate feedback that will improve future service delivery.

- **Procedure:** If during or at the time of follow up additional assistance such as home visit, office appointment or community appointment occurs or a new need is identified, a new contact shall be logged in and action recorded.

- **Procedure:** SLRC staff will use follow up as the scheduling system for appointments, sending packets of information and cover letters. See Refer 7.5 Manual, Call Module Page 34 for more details.

Policy 575: Modification requests will be submitted in writing to the System Administrator for consideration. See Refer 7.5 Training Manual for current System Administrator.

Policy 580: SLRC staff that discover errors or outdated information in the resource database will report the information to the resource manager within 2 business days of the discovery.

- **Procedure:** SLRC staff will encourage and support agencies to report errors and outdated information to the Refer7 System Administrator. ServiceLink staff will refer agencies to the tools created for providers in order for them to make a report.
- **Procedure:** If appropriate, SLRC staff can facilitate the completion of the update/delete form ONLY. This would be to assist in reporting errors or outdated information in the database.
- **Procedure:** SLRC staff will formally verify the information with the agency and provide documentation stating agency contact occurred.

- **Procedure:** Upon receipt of the updated information, the Refer 7 System Administrator will make appropriate changes within three weeks.

Policy 585: All SLRC offices will document unmet need according Definition and Procedure for determining unmet need. See Definition and procedure in Refer 7.5 Manual.

Glossary:

Action: An action is one of three types of assistance a SLRC staff person gives to a contact. At least one of these actions must be saved to record a call to the Refer7 database.

- Referral
- Unmet Need
- Reason for Call

Contact: A contact is when a staff person at the SLRC is contacted by telephone call, walk-in (responds to a person who drops by the office without an appointment), home visit, appointment (in office or in community setting), email, letter or fax with a person looking for resources.

NOTE: Calling or contacting agencies on behalf of a contact person is not a contact.

> **Example**: A contact person is working with the I&R Specialist. As a result of this call, the I&R Specialist need to research and advocacy on behalf of the caller. In order to do this, the specialist I&R Specialist calls 4 agencies to gather information and get back to the contact person. The calls to agencies are NOT additional contacts in the Refer7 system.

Contact Person: The person initiating the event from the community.
Types include: Caregiver, friend/relative, provider, govt. agency, community group, self, and other.
Caregiver - Family members or friends, usually uncompensated, who assume responsibility for attending to the daily needs of individuals who are temporarily or permanently unable to completely care for themselves due to general frailty; illnesses, injuries or progressively debilitating conditions such as Alzheimer's disease or mental illness; or other incapacitating problems.
Community Group - Organizations or groups of individuals who have common interests or concerns who have joined together on a voluntary basis to provide targeted services for the community, e.g.: religious groups.
Friend/Relative - An individual who has a personal relationship with the person who they are calling about but are not that person's caregiver.
Government Agency - An entity, by which a community or other political unit is governed, can be town/city/county/state/federal.
Provider – A worker from an entity that provides services to our clients.
Other - Callers who are not categorized in any of the above.
Self- An individual calling on their own behalf.

APPENDIX L

Client: The client is the person the information or resources being sought. In cases where the contact person is calling for himself or herself the contact would be the client.   The contact may be calling for information or resources that will help someone else not themselves; in this case, "someone" is the client. Client types include: Caregiver, disabled adult, friend/relative, older adult (60 or older), provider, and unknown.

ServiceLink Resource Center (SLRC) Information and Referral Service: Organization whose primary function is to link people in need of human services with appropriate service providers who can meet their needs. These services can be comprehensive, covering the whole range of human services or specialize in resources for a particular population.

Note: For terms not defined above, the Glossary Definitions as stated in the AIRS Standards for Professional Information and Referral Systems will be used. (See attached)

SERVICES

Information Provision: The information provision is the process of providing descriptive information about a service provider to the inquirer. Information can range from a limited response (name, telephone, address), to detailed data about community service systems (such as explaining how a group intake system works for a particular agency), agency policies, and procedures for application.

> Examples of Information provision include: (for more detail go to page 29 of the Refer7 Call Module)
> - ❖ Responding to a request for the number for a food pantry. **(Basic needs information)**
> - ❖ Responding to a question: what home health agencies are available in my town?
> - ❖ Responding to a request for a ride to the doctor's office.
> - ❖ Responding to a request for phone numbers or addresses. **(Service Provider Info)**
> - ❖ Assisting a contact with directions.
> - ❖ Assisting a contact with CFI education.

Referral Provision: The process of assessing the needs of the inquirer, identifying appropriate resources, assessing appropriate response modes, indicating organizations capable of meeting those needs, and providing enough information about each organization to help inquirers make an informed choice. Helping inquirers for whom services are unavailable by locating alternative resources, and when necessary, **actively** participating in linking the inquirer to needed services by scheduling appointments, three-way calling, or negotiating for the inquirer. This will be recorded by way of the total referrals made by staff for a person contacting the SLRC.

Total Amount of Time Spent: Total amount of time spent on the system processing events is recorded in IT system automatically once a staff person opens a call. Time for events that are managed on the Refer7 system such as home visits, scheduled appointments, long-term support counseling, research, travel, etc. will at all times be added to the contacts captured in Refer 7 by editing the contact and adding the extra time.

Follow-up: The process of contacting a contact or client to determine whether the resources they were referred to met their needs. At all times staff will fill out the unmet need screens for those referrals that did not help.

Procedure # 100
SLRC Incomplete/Transfer Contacts

Effective Date: 4/1/2010 updated 12/1/2015serv12/1/15

Approved By: SLRC Network

Purpose:

The purpose of this procedure is to:

- Ensure consistent documentation of incomplete and transferred contacts throughout the SLRC Network.
- Accurately reflect the activity and services provided by the SLRC.

1. Contacts within "your" SLRC office:

When a person contacts the SLRC, the team member will start a contact in Refer7. All pertinent demographic information will be documented in Refer7 including a note in the Client Notes page.

If it is determined that another in-house SLRC staff member or another SLRC site is needed to assist the consumer the intake SLRC staff member will follow the steps below:

The original team member spends time educating/informing consumer of a subject. If the consumer is being transferred to another staff person, in-house, regarding any subject matter (whether specialized or not) the contact will be saved as "INCOMPLETE" in Refer7 to the other SLRC staff member. Complete notes in the Client Notes page will be documented.

Note: Each SLRC has the choice to add additional and customized steps based on their offices operations and staffing pattern. The following examples demonstrate the steps outlined above.

a. Contact started in Refer7. Subject matter is Medicare. Team member does basic Medicare education with the consumer. It is determined that consumer needs assistance with picking a Part D plan. The contact is transferred as "INCOMPLETE" to the Medicare Specialist.

b. Contact is started in Refer7. Subject matter is Fuel Assistance. Team member does I&R/A. Through an assessment of other needs, the team member needs to <u>refer</u> the contact to the LTS Counselor for a more specialized assessment. The contact is ENDED. A new contact is initiated and transferred as "INCOMPLETE" so that the LTS Counselor can pick it up.

c. Empty space for individual ServiceLink offices to customize their own examples related to how their office operates.

2. Incomplete/Transferring to a different SLRC Location

Step 1: When a person contacts the SLRC and it is determined to be more appropriate to be transferred to another SLRC location the team member will start a contact in Refer7. All

available demographic information will be documented in Refer7. Information will be documented in the Client Notes page of Refer7. The originating staff person will end the contact in Refer7.

Step 2: A new contact is started in Refer7 and transferred as incomplete to the appropriate staff person in the different SLRC location.

Step 3: The transferring SLRC will type TRANSFER CALL in transfer notes and click date and staff ID.

Step 4: A pop up will display asking if the contact should remain in your office. If additional work needs to be completed answer "Yes". This will transfer the contact to the receiving office but keep it in the team member's list as well. Answering "No" will completely transfer the contact to the receiving office and remove it from the team member's list of incomplete calls.
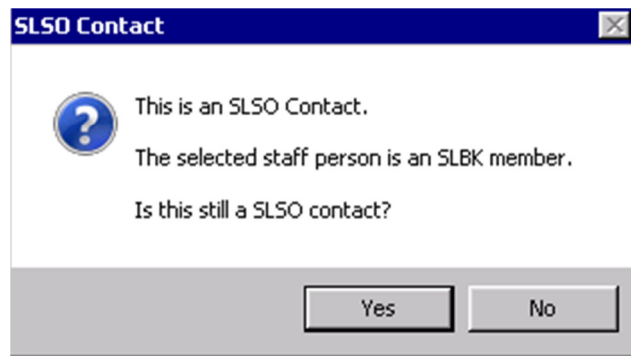
Figure above is for a contact originating in the SLSO office being transferred to a staff member in SLBK office. Answer yes and it stays in the YOUR list as well as theirs. Answer no and it transfers to the other staff and is removed from your list.

Step 5: The transferring SLRC will email the receiving staff person, with a cc: to the Center Manager at the other SLRC location to let them know that an incomplete call is in their name.
Step 6: If team member does not have enough information to determine whom the incomplete contact should be transferred to, it will be transferred to the Information and Referral Specialist.
Note: A link to the most current SLRC Network staff directory can be found in eStudio.

APPENDIX L

Procedure # 110	Effective Date: 3/1/2010
Title: LTS Options Counseling Packets	Approved By: SLRC Network

Purpose:

The purpose of this procedure is to:

- Ensure consistent information is communicated to NH Citizens who are looking for LTS Options Counseling
- Accurately reflect the activity and services provided by the LTS Counselor related to follow-up.

The following table outlines the minimum standards for consumer packets related to Choices for Independence, Nursing Facility Care, and LTS Options Counseling.

Packets sent to consumers will use this format. All packets can be further customized based on consumer need.

Items	CFI Packet	NF Packet	Long Term Care Packet
Appt. time for DFA/Counselor	If appropriate	If appropriate	If appropriate
APTD application	If appropriate	If appropriate	
APTD description	Brochure	If appropriate	
Authorized Representative	If appropriate	If appropriate	
Business card	✖	✖	✖
CFI Booklet	✖		
CFI brochure	✖		If appropriate
Cover Letter	✖	✖	✖
Directions to the SLRC	If appropriate	If appropriate	If appropriate
List of Verifications	✖	✖	
MED Application	If appropriate	If appropriate	
Medical Release forms	If appropriate	If appropriate	
Meet the staff document	✖	If appropriate	✖
NH Legal Aid Booklet		If resource assessment	If appropriate
Resource assessment verification list		If resource assessment	
ServiceLink brochure	✖	✖	✖
Transitions in Caregiving information			If appropriate

Customized Long Term Care Options Counseling Information typically distributed:

Adult Day or Day Out

Advanced Care Directives

Alzheimer's association

Choosing a Nursing Home

Home Health Agency level of care, how to choose, and information about agency options

Hospice

Long Term Care Insurance Info

LTC Planning Kit (CMS developed)

Planning for the Future booklet

Private caregiver list and how to hire a private caregiver

Support Groups

APPENDIX L

What is a POA for Finances or Health Care
What is Assisting Living, How to Choose
www.medicare.gov- for home health and nursing home ratings

APPENDIX L

ServiceLink Policy and Procedure #200: Follow Up	
Policy Name:	**Information, Referral & Assistance Follow-up Policy**

Section: 200
Initial Approve Date: 8/30/2013
Last Approve Date: 9/6//2013
Written by: ServiceLink Network
Last Draft Date: 9/6/13, 6/22/15

Policy 205: Follow-up will be conducted with the people who contact SLRC for information and assistance, to determine outcomes and to provide additional assistance in locating or using services as appropriate.

Policy 210: Follow-up on information and assistance will be conducted within no more than fourteen (14) business days of the service. *(Note: There may be instances when follow up is conducted before or after the 14th day based on a person centered approach to follow up. ServiceLink staff and volunteers will use professional judgment regarding when to follow up)*

Policy 215: Follow-up types will be identified and documented for monthly reporting to BEAS.

Policy 220: Establish statewide procedures for conducting and documenting follow up in accordance to the Information, Referral & Assistance Policy.

Procedure # 200 **Title:** **SLRC Follow up Procedure**	Effective Date: 9/6/2013, September 1, 2015 **Approved By: SLRC Network**
Goal: People receive information and assistance to get what they need. **Purpose:** The purpose of this procedure is to: • To check on the safety of the customer. • To find out whether the customer received the information that was sent. • To ask "Is more assistance needed?" • To see if the person has more questions. Often people don't know what to ask for in the initial conversation. • To provide more help when the person is unable to do it himself. • To develop rapport with a person(s) who is likely to develop a need for additional assistance. • To provide coordination of services and/or referrals.	
1. In General ServiceLink ADRC staff and or volunteers will: • Use the AIRS *Standards for Professional Information and Referral* as a starting point. These are available at http://www.airs.org/. • Follow up doesn't do any harm, so it's better to err on the side of overdoing it. • Encourage discussion and review of persons' situations by I&R/A Specialists, supervisor and/or colleagues to support appropriate follow-up. **2. Refer 7 System and Contact Module Policies and Procedures Policy #570 regarding follow up will be used.** • When ending a contact in Refer 7 all staff will be prompted to choose **yes or no** when request box	

prompt is activated. It will say: *"You did not schedule a follow up for this contact. Would you like to do that now?"* Staff will use procedure 200 #3 and #4 as guidance when choosing **yes or no**.

- If you choose yes, it will bring you to the follow up module. If you choose no you will continue on by ending the contact. BEAS will track numbers of yes and no answers chosen.
- Refer 7 will track follow-up on inquiries and acts a coordination tool for scheduling appointments, sending packets of information and cover letters.

2.a Staff will utilize Refer 7 ***Follow up contact data form*** to document the outcomes of follow up activities. The data form is to be used when staff is following up on inquiries and services provided. When closing out follow-ups related to scheduling or prompting purposes, the data form is not required.

3. **When to Follow Up:** Follow up is conducted when possible, with the permission of the inquirer and never compromises inquire safety. Follow up is conducted when:
    - Supplemental contacts need to be made such as several calls, subsequent office or face-to-face meeting.
    - An application needs to be submitted by or on behalf of the customer.
    - Information has been sent to the person.
    - The person making the inquiry has multiple concerns.
    - The amount of I&R/A may overload the customer.
    - There has been a history of problems with the organization to which you are making a referral.
    - When dealing with new or unfamiliar services or providers.
    - In situations involving crisis, emergencies or endangerment. (The ADRC should have a separate policy for this.)
    - A home visit has occurred.
    - Basic needs of food, clothing and shelter were identified as primary issues.
    - A person appears to be unable to proceed with the information independently.
    - The person is unsure, upset or disappointed.
    - The person is starting through a long process that is complex.

4. **When Not to Follow Up**
    - The conversation is brief and specific, and sufficient information does exist to conduct follow up as in a request for a phone number or a simple referral and call back information is not collected or it is an anonymous caller.
    - After follow up is offer, the person has indicated that he or she does not wish to have a follow up contact.

Additional Considerations
    - It is best practice to ask permission to follow-up.
    - Make sure you are talking to the right person during the follow-up call.
    - Avoid disclosing sensitive information or violating confidentiality. Insure that confidentiality policies address scripts or guidance for staff when calling someone back or leaving messages. This may also include circumstances where blocking the SLRC phone number for Caller ID.

APPENDIX L

SCREEN SHOTS NEEDS UPDATED:

<mark>Screen shot of prompt when ending a contact. This will display if a contact has not already been scheduled. Saying yes brings you to the follow up scheduling screen. Saying no allows you to end the contact. BEAS and Supervisors will track numbers of Yes and No answers and follow up as needed.</mark>

Screen you will see when reviewing your follow ups that need to be performed.

very long# APPENDIX L

Within the perform follow up screen there is a follow up survey. The survey is to be used when documenting each performed follow up. The screen below displays the location of the survey.

In connection to the goal and purpose of follow up, ServiceLink will use the follow up survey to document outcomes of inquiries.   The Follow up data form is to be used when staff is following up on inquiries and services provided. When closing out follow-ups related to scheduling or prompting purposes, the data form is not required. When staff choose the survey it will be prompt staff to answer the displayed question. Record the answers based on contact response.

APPENDIX L

Follow Up Type List and Definitions (In Development)   Updated

APPENDIX L

Definitions:

NEEDS DEVELOPED FOR THIS UPDATE
Call client/consumer:
Call provider:
Mail information to client/consumer:
Community visit/appointment scheduled:
Email client/consumer:
Home Visit Scheduled:
Office Visit Scheduled:
Appointment scheduled-Hospital:
Appointment scheduled-Nursing Facility:

Proposed Addition:

Medicare Research: Follow up to prompt staff to check or re-run a Part D comparison, check if client is on LIS or QMB as part of screening process, prompt for Part D enrollment assist.

REFER 7 TRAINING

Appendices A-O

ServiceLink

Aging & Disability Resource Center

System User Confidentiality Agreement

I. Client Confidentiality

As a representative of the ServiceLink Resource Center organization, I understand I have access to confidential information, some of which is personal and is, by law, considered confidential. I will at all times treat this information as confidential, and will disclose this information only to explicitly authorized individuals and/or organizations for the purpose of service delivery. I will not access or share confidential information for any reason other that to perform my job duties.

Initial: _____

I understand that client confidentiality is of utmost importance; therefore, I agree to take the necessary measures to ensure that all client information is handled in strict confidence.   Initial: _____

II. System Access

I acknowledge that I have been assigned a user ID and password that is to be used ONLY by myself to access the Refer7 Client Tracking System and/or Options. I understand that I will be held accountable for all actions and activities produced by my user ID. I will not share my ID and/or password with anyone, and I will not use the ID and/or password assigned to someone else.

Initial: _____

I will not enter any unauthorized data or change or alter existing data in a manner inconsistent with my job duties. Under no circumstances will I enter knowingly false data that may compromise the integrity of the system.

Initial: _____

I agree not to attempt to intentionally cause the system to malfunction or knowingly alter data without authorization in an effort to compromise the computer security system. I further agree to report any suspected misuse or lapse in the security system.

Initial: _____

III. Statement of Understanding

By signing this agreement I acknowledge that I understand the purpose and intent of the Refer7 system and /or Options, and understand the relationship of these databases and the organization with which I am employed. I understand that maintaining client confidentiality is my first duty and largest responsibility as a user of any system. I acknowledge that I have read, understand, and voluntarily agree to follow the guidelines set forth above. I further understand that failure to follow these guidelines may result in possible termination of Refer7 and/or Options privileges.

_____   _____
Name   Email Address

                                                                               _____
_____   User ID
Signature   _____
                                                                                    Date

APPENDIX L

_____   _____
ServiceLink   Signature Date
Program Director/Manager/Fiscal Agent

Appendix B: Long Term Care (LTC) and Options Counseling

Refer Data Element	Content	Location in Refer	When to use it
Options Counseling Triggers	CFI/NF/Medicaid Concerns about care Long Term Supports Needed Planning for future care Significant change in circumstances	Contact Data Element found on Page 3. Data, Far right column near the bottom.	Staff should identify these as triggers for referral to Options Counseling and to mark the appropriate trigger to identify the specific reason for a referral to OC.
Refer Data Element	Content	Agency Referred to	When to use
Referral(Taxonomy Term)	Long Term Care Options Counseling	SLRC	Used by SLRC team when making a referral to LTS Options Counseling, and used by Long Term Support Counselors when providing 1:1 Long Term Care Issues
	Long Term Care Options Counseling*Medicare Recipients	SLRC	Used by Options Counselors when providing counseling on Long Term Care for those receiving Medicaid
	Transitional Case/Care Management	SLRC	Used when OC Staff provides person centered transition support with individuals who are experiencing a specific, time-limited problem such as transition from hospitalization to independent living, rehab to home, nursing home to home or vs./vs., move from one living situation to another and who need assistance to obtain and coordinate the support services that will facilitate the change
	State Medicaid Waiver Programs	BEAS state office for Choices for	Used when referring individuals to CFI or NF Medicaid and/or when

Refer Data Element	Content	Location in Refer	When to use it
Options Counseling Triggers	CFI/NF/Medicaid Concerns about care Long Term Supports Needed Planning for future care Significant change in circumstances	Contact Data Element found on Page 3. Data, Far right column near the bottom.	Staff should identify these as triggers for referral to Options Counseling and to mark the appropriate trigger to identify the specific reason for a referral to OC.
		Independence (CFI)	entering app in New Heights.
	Certificates/Forms Assistance*Medicaid	Your SLRC office	Used when assisting in completing a Form 800 and/or when entering CFI or NF Form 800 in New Heights
Refer Data Element	Content	Location in Refer	When to use it
Reason for Call	Long Term Care Information	Top menu bar under Reason for Call	When providing information by phone, in person, or when providing information by phone, in person and mail about LTC supports. *This would also be used to document mailings that occurred during an Options Counseling contact. If it occurred after the contact, (example one week after call), it should be added to existing contact in order to document that information was mailed within that or as a result of that contact. EXAMPLE: Call 9/1 Mailing sent on 9/5. LTC Information reason for call would be added to the 9/1 contact. Not added as a new contact. Note: This should not be

Refer Data Element	Content	Location in Refer	When to use it
Options Counseling Triggers	CFI/NF/Medicaid Concerns about care Long Term Supports Needed Planning for future care Significant change in circumstances	Contact Data Element found on Page 3. Data, Far right column near the bottom.	Staff should identify these as triggers for referral to Options Counseling and to mark the appropriate trigger to identify the specific reason for a referral to OC.
			used to document contacts that represent mailings going out. This work is part of a contact when used for mailings.
Client Marker	Use when one of the client markers matches the consumer's situation.	Located in the Add New/Edit Client screen in the bottom right corner	Use the client marker that matches the consumer's situation.
Client Data	Information pertaining to referral source for Options Counseling, household make up, marital status, legal documents and arrangements. Mark as much information as you have, as more becomes available or if things change, add and edit	Located in the Add New/Edit Client screen in the top right section.	Complete as many Client Data fields as you can. Especially for those receiving Options Counseling.
Contact Marker	Mark based on the type of contact you had.	Page 3. Data in the center column	Use the contact marker that matches the type of contact you're having (phone, office visit, etc).

Figure 1. This info prepopulated from Client record

Figure 3. This is the Matchlist where the search results are displayed. Double click the blue text to save a referral.

Figure 2. Select the taxonomy term Long Term Counseling and/or the term with *Medicaid Beneficiaries. Other taxonomy can be substituted depending on the type of call. See note below.
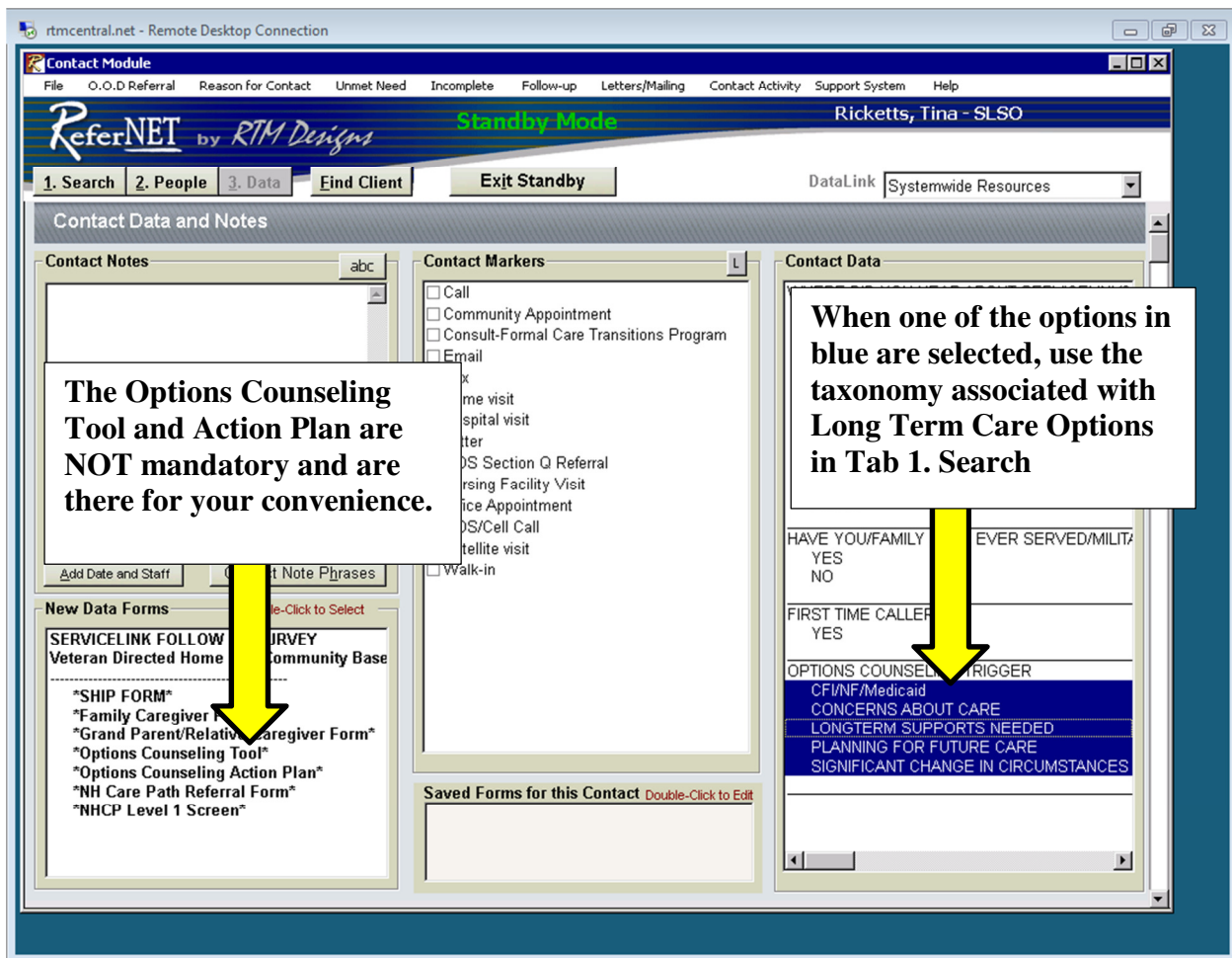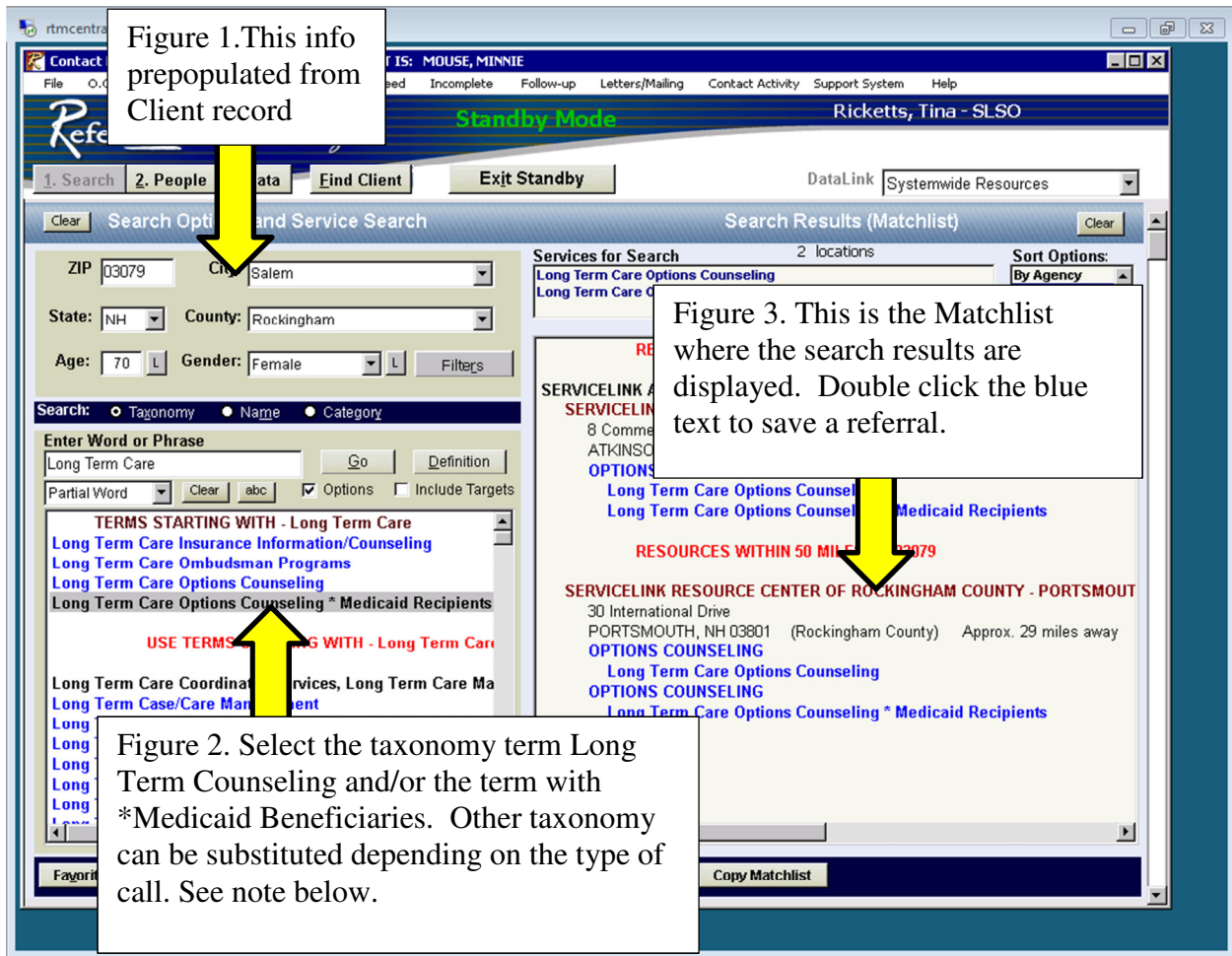
Figure 1. Information will be prepopulated in this box if you have already entered them or loaded them as an existing client.

Figure 2. Enter the appropriate taxonomy term for the service that you are searching for. You do not have to enter the full term, and it is better to be brief to yield the most results. See below for a list and definition of LTC and Options Counseling taxonomy terms.

Figure 3. The results of the taxonomy search appear in this box. The list of resources is referred to as the Matchlist. In order to save a referral, click on the blue text to open the additional information window.

LONG TERM CARE OPTIONS COUNSELING (COUNSELING (LH-4600) Programs that offer an interactive decision support process that helps individuals in need of long term care and their families understand their strengths, needs, preferences and unique circumstances and weigh the pros and cons of available alternatives. The consultation includes a discussion of the factors to consider when making long term care decisions, information about the range of long term care support options available in their community (such as personal care, transportation and medication management) and resources that can help them pay for services. The program also

provides decision support to help identify next steps in the process and help in connecting with services, if needed. The service is generally available to older adults and adults of any age who have a disability; can be of benefit to people using their own resources to pay for services; and may be provided over the telephone or in person (at home, at an agency in a hospital, at a rehabilitation or nursing facility or in another setting of the person's choosing). The objective of the program is to allow people to live as independently as possible in the setting of their choice

TRANSITIONAL CASE/CARE MANAGEMENT (PH-1000.8500) Programs that develop, implement, assess and follow up on plans for the evaluation, treatment and/or care of people who are experiencing a specific, time-limited problem such as a transition from hospitalization to independent living and who need assistance to obtain and coordinate the support services that will facilitate the change.
USE TERM(S):
Section Q, Short Term Case Management, Transitional Case Management

STATE MEDICAID WAIVER PROGRAMS (NL-5000.5000-800) Medicaid programs offered by states that have been authorized by the Secretary of the U.S. Department of Health and Human Services (HHS) to waive certain Medicaid statutory requirements giving them more flexibility in Medicaid program operation. Included are home and community care based (HCBC) waiver programs operated under Section 1915(c) of the Social Security Act that allow long-term care services to be delivered in community settings; managed care/freedom of choice waiver programs operated under Section 1915(b) of the Social Security Act which allow states to implement managed care delivery systems or otherwise limit individuals' choice of provider under Medicaid; and research and demonstration project waiver programs operated under Section 1115 of the Social Security Act to projects that test policy innovations likely to further the objectives of the Medicaid program. Each of the states has developed waivers to meet their needs; and while every state's waiver programs have their own unique characteristics, there may also be common threads.

Appendix C: NH Family Caregiver Program Tip Sheet

Refer 7	Content	When to Use
Page 3. **Contact Marker**	Mark based on type of contact you had.	Use the contact marker that matches the type of contact you're having. (phone, office visit, etc.)
Page 2. **Contact Person Type**	Caregiver	Use the contact person type caregiver when the person calling identifies, or is determined to be a family caregiver and/or determined to need 1:1 caregiver support or counseling.
Client Data	Required information: • Name • Address • Gender • Date of Birth • Monthly Gross Income Client Data box: (required) • Client type • Race • Caregiver relationship • Referral source for Options Counseling/Caregiver • Household make up • Marital status • Legal documents and arrangements Scroll down to mark as much info as you have, as more info becomes available or if the situation changes add and/or edit.	On "Edit Client" page, complete as many **Client Data** fields as you can. Especially for those receiving Options Counseling/Caregiver Counseling.
Client Marker	Use when one of the client markers matches the consumer's situation. REMEMBER THE CAREGIVER IS THE CLIENT	Use when the client marker matches the consumer's situation
Associated People	Add care receiver as an Associated Person. Search to see if they exist, select or add a new person and save	When connecting a caregiver to a care receiver for purposes of Options Counseling/Caregiver Counseling

	appropriate relationship	
Reason for Call	Use when providing info and documenting what occurred during the contact.	When providing information by phone, in person or by mail. *This would also be used to document mailings that occurred during an Options Counseling/Caregiver Counseling contact. If it occurred after the contact, (ex. One week after call), it should be added to existing contact in order to document that info was mailed within that or as a result of that contact. EXAMPLE: Call 9/1 mailing sent on 9/5. Caregiver information **Reason for Call** would be added to 9/1 contact. Not added as a new contact. *Note This should not be used to document contacts that represent mailings going out. This work is part of a contact when used for mailings.
Follow Up	NHFCG Program 6 month check ins (Options Counselor/caregiver specialist only) *Other general follow up reasons as needed. Email reminder, schedule home visit or office visit mail information reminder, etc.	Counseling to assess for changes and updates to caregiver subsidy plan and person centered plan. When reminding or scheduling activity for a future date as a result of a contact

Referal: It is important to note that these referrals are tied to the NH Family Caregiver Program work. If the staff doing this work also provide Person Centered Options Counseling, SHIP, etc. other documentation and processes also apply.

Step 1. Open a call and record basic information

Step 2. Locate or add a new client and contact person. – This step will save you having to enter extra info into the forms or services later.

Figure 1. Client is the **CAREGIVER.** This may or may not be the person you are speaking to, but it is the person the call is about.

Figure 3. Contact Person is the person you are speaking with, it can be the caregiver if they are calling about themselves, a social worker, a family member etc.

Figure 2. If the Care Recipient is not the person you are speaking to, they are NOT the contact person but a Person Associated To This Client. See additional notes below.

Figure 1. The Client is the person that you are speaking about. In the case of the NH Family Caregiver Program, the client is the CAREGIVER, since they are the person in need of services.

Figure 2. People Associated to this Client should be used to record, at the least, the information for the Care Recipient. If the person you are speaking with someone other than the Caregiver/Recipient, then that person can also be listed as associated but then made into the contact. Ex. Social Worker calls on behalf of Minnie Mouse who is the caregiver for her friend Abe Simpson, the client is Minnie Mouse, the contact is the Social Worker and Abe Simpson is a Person Associated to this Client.

Figure 3. The Contact Person is the person you are speaking to. This person could be the Caregiver if they are calling about themselves, it could be a social worker, the care recipient or anyone else.

Step 3. Complete the Appropriate Caregiver Form – There are two forms located in Tab 3. Data section of the call. Click on the appropriate form.

rtmcentral.net - Remote Desktop Connection

Contact Module CURRENT CLIENT IS: MOUSE, MINNIE

File O.O.D Refer

Family Caregiver Form

Family Caregiver Form

Specialist Name:
Tina Ricketts
(First Name) (Last Name)

Research: ☐ Yes ☐ No

Rural: ☐ Yes ☐ No

Date of Initial Contact: 09/10/2015

Length of Time in Program:

Referral Source:
☐ Hospitals
☐ Nursing or Rehab
☐ ADRC
☐ CILs
☐ Home Health Agency
☐ Adult Day
☐ Individual

Services Utilized:
☐ Nursing Care at home
☐ Personal Care
☐ Homemaker Services
☐ Chore Services

☐ Respite Care
☐ Caregiver Support
☐ Support Group
☐ Powerful Tools for CGs

☐ Home Delivered Meals
☐ Home Modifications
☐ Occupational Therapy
☐ Assistive Technology
☐ Environment Services
☐ Other Goods & Services

Some info is pre-populated from the client record. This includes your name, the name, gender, DOB, and age range of the Caregiver or Client

Section 1 : Caregiver Specific Information

Name of Caregiver:
Minnie Mouse
(First Name) (Last Name)

Ethnicity of Caregiver:
☐ Hispanic Origin
☐ Non Hispanic Origin
☐ Unknown

Marital Status of caregiver:
☐ Never Married
☐ Married
☐ Divorced

Gender
☐ Male ☑ F

Make sure that the Care Recipient is the person in this box. Refer will pre-populate with the Contact Person's Info, and you must change it if it is incorrect.

th Partner

Age of Caregiver:
Date of Birth:
01/01/1945

☐ Under 60
☑ 60 - 74
☐ 75 - 84
☐ 85+
☐ Unknown

☐ Some Other Race
☐ Unknown

of Caregiver to Care

-in-law
r/Daughter-in-law
☐ Other Relative
☐ Non- Relative
☐ Unknown

Section 2: Care Recipient

Name of Care Recipient:
Social Worker
(First Name) (Last Name)

Functional Impairments Status:
☐ 0 ADLs ☐ 4 ADLs
☐ 1 ADLs ☐ 5 ADLs
☐ 2 ADLs ☐ Unknown

Cognitive Impairment
☐ Yes
☐ No
☐ Unknown

Gender

The Grand Parent/Relative Caregiver Form will pre-populate with the same Caregiver info that the Family Caregiver form will. You will still need to collect the information for the Care Recipients or grandchildren as it will not bring in that info.

You must click save before you can print.

Step 4. Make the appropriate referral. Click on Tab 1. Search and you will notice that the zip code, city, state, county, age and gender are pre-populated based on the info you already collected in the client record. There are 3 different ways that you can search for the correct term to use, by Taxonomy Term, By Name of agency, and by Category system.

Searching by Category will allow the staff member to see all of the terms affiliated with caregivers in one place. The first category is for Caregiver Supports. Clicking on the "+" will expand the choices and help to narrow down.

Searching by name is effective if you know the name of the organization or program name. For example, in the case of the New Hampshire Family Caregiver Program, I know that the referral should be saved to ServiceLink and that the name of the program is something to do with family caregiver though I don't know if its been entered as NH, New Hampshire, or N.H. The best thing to do would be to either search for ServiceLink or as much of the name of the program as I know bearing in mind that when searching in Refer everything has to be exact.

 Searching by Taxonomy will require that you are specific with the wording of the term that you are searching for. The % sign can be used to substitute for any character but it should be noted that everything in front of and behind the symbol must be exact.
Below is a list of the caregiver related taxonomy terms and their definitions. Some terms such as Family Caregiver Subsidies have an "*" followed by a target term such as Kinship Caregivers. This is to indicate which program is specifically for the Grandparent / Relative Caregiver program.

Taxonomy Definitions:
CAREGIVER COUNSELING (RP-1400.8000-145)
Programs that provide emotional support, information and guidance in individual and/or group settings for family members, friends, significant others, non-familial caregivers or attendants who are caring for someone who has a serious illness or disability or who is elderly and increasingly unable to provide for his or her own care, and are feeling overwhelmed by their responsibilities and the effect that their caregiving role has had on their lives.

FAMILY CAREGIVER SUBSIDIES (NL-3000.1900)

Programs that use federal, state, local and/or other funding to provide financial assistance for family members (or other persons such as neighbors) who are serving as informal primary caregivers for frail elderly individuals or, in some cases, for adults with disabilities; for grandparents caring for grandchildren; or, in some jurisdictions, for families caring for children with severe disabilities. Age and other eligibility criteria may vary by area. Assistance may be provided in the form of cash to the consumer/caregiver, vouchers, which can be redeemed with approved service providers or through pro bono services, donated by local service providers to a service bank for family caregivers. The objective of the program is to make it possible for primary caregivers to obtain the assistance they need in order to continue in their caregiving role which, in turn, enables the frail elderly individual or person with a disability to remain in the community.

CAREGIVER/CARE RECEIVER SUPPORT GROUPS (PN-8100.1400)

Mutual support groups whose members are family, friends, significant others, non-familial caregivers or attendants who are caring for someone who has a temporary, chronic, life-threatening or terminal illness or disability or who is elderly and increasingly unable to provide for his or her own care. The groups meet in-person, by telephone or via the Internet; and provide emotional support, information and resources to help participants ensure their own well-being while remaining involved in the intense care of a loved one. Also included are care receiver support groups that help people who have a caregiver cope with the fact that they require care. Care receiver support groups are often offered in conjunction with caregiver support groups and are structured to allow care receivers to participate in their own group while their caregiver attends another.
USE TERM(S):
Care Receiver Support Groups, Caregiver Support Groups, Caregiver's Support Groups, Children of Aging Parents Support Groups, Support Groups for Caregivers

Guidance for Unmet Need Related to Caregiver Grant Funds not being available:

Based on the definition of unmet need, if someone needed the caregiver respite grant and fell into the criteria set forth it would be true unmet need with the reason of: **Program Has No Capacity,** The identified service does exist, but the program lacks capacity to offer it to the individual. (This applies to programs that are putting potential clients on waiting lists because they are full, or because they lack the necessary human resources to provide the service.) (We may want to expand on this and say that this also applied to program existing but money has not been released as available in order to access the service)

IF the caregiver doesn't pass the test of:
 • The consumer requires a specific service "immediately"*;
 • The consumer is "at risk"*; and

- The consumer is a "willing consumer"*.

THEN: The need would be marked as community unmet need. This way it is still recorded as unavailable and we can determine of those that requested who was true unmet need by definition and who needed it but could live without it for a period of more than two weeks/was not at risk, and perhaps could access other services until then.

Appendix D: Medicare Counseling/Part D/MIPPA and SMP

- When documenting a contact and providing I&R, Counseling, or enrollment assistance on behalf of a consumer, the "Call/Contact" related to your work should be open in Refer 7 so it will capture your time. If you forget or are unable to do this, see below for how to add time.

- Search for the consumer you're working with and click the "client is the contact person". If you're talking with a provider or family member regarding the client, find the client, and then on Pg. 2 people, find the contact person. Watch for duplicates!!

- You can minimize Refer 7 while you're on Medicare.gov.
  Below is guidance for doing your work related to **Medicare Counseling/Part D/MIPPA and SMP**

-

Where the caller heard about ServiceLink

When you send a Medigap packet to a consumer

For use when only providing info about SMP.

Finding the correct taxonomy term to log a Medicare Call: When searching for the correct term to use to record your work with Medicare, there are 3 different methods that can be used to locate the right resource. Those methods are Taxonomy, Name, and Category.

If using the Category method of searching, choose Medicare from the list of categories and click on the "+" to expand the selections. This will display the entire list of Medicare related taxonomy terms.

Searching by name is effective if you know the name of the organization or program name. For example, in the case of Medicare, I know that the referral should be saved to ServiceLink and that the name of the program is something to do with Medicare, though I don't know if the exact taxonomy. The best thing to do would be to either search for ServiceLink or as much of the name of the program as I know bearing in mind that when searching in Refer everything has to be exact.

If you know the correct taxonomy term to use, searching using that taxonomy can be the quickest way to reach the ServiceLink listing. Consult the taxonomy table for the correct taxonomy to use.

Medicare Counseling, Medicare Savings Program (MSP), Low Income Subsidy (LIS), and Medigap

Taxonomy Term	Agency Referred to:	Type of Work Done
Medicare Information/Counseling ***For use by SHIP certified or trained counselors/volunteers only**	ServiceLink	When you talk in general about Medicare or Medicare related programs or when you're doing a comparison or other Medicare related research including Medicare Part D comparisons.
Agency Based Libraries/Resource Centers*Medicare Beneficiaries ***Use only if you are NOT SHIP certified**	ServiceLink	When you talk in general about Medicare or Medicare related programs or when you're doing a comparison or other Medicare related research including Medicare Part D comparisons.

Medicare Prescription Drug Plan Enrollment	CMS	When you actually assist someone in enrolling in a Part D plan online, or you can tell them how to either enroll via phone, online or mail.
Certificates/Forms Assistance*Medicare Beneficiaries	ServiceLink	When you assist with forms, paperwork, applications, in addition to your Medicare Counseling and is NOT related to LIS (Low Income Subsidy) or MSP (Medicare Savings Program)
Medigap Information **(Note this is a Reason for Call not Taxonomy term)**	ServiceLink	When you send a Medigap packet to a client.
Medigap Insurance Counseling	ServiceLink	When you do counseling with someone in reference to their Medigap options
Medicare Part D Low Income Subsidy Applications	Social Security	When you **REFER** someone to Social Security for LIS or send them an LIS application
Medicare Savings Programs	DHHS	When you **REFER** someone to the Medicare Savings Program (QMB/SLMB) or send them an application
Medicare Part D Low Income Subsidy Applications *AND* Certificates/Forms Assistance*Low Income	ServiceLink	When you **ASSIST** someone in completing an LIS application – either online or a paper form. Note you must save a referral to both of the taxonomy terms.
Medicare Savings Programs *AND* Certificates/Forms Assistance*Low Income	DHHS and ServiceLink	When you **ASSIST** someone in completing a Medicare Savings Program (MSP) application – a paper application or through NH Easy.
Fraud Prevention*Medicare Beneficiaries or Medicare Fraud Reporting	ServiceLink	One on One Counseling or Education – Call or contact where more research, specific information, PHI, education and individual assistance is provided on a complaint or question about a suspicious

		billing error (e.g. excessive charges an unrecognized provider name, or an x-ray interpretation billed on a Medicare Summary Notice).
Medicare Complex Issue Fraud Reporting	ServiceLink	When working on and/or referring an SMP contact or call that develops into a complex issue that requires research and further investigation by **another agency.**

Taxonomy:

MEDICARE INFORMATION/COUNSELING (LH-3500.5000)

Programs that offer information and guidance for older adults and people with disabilities regarding their health insurance options with the objective of empowering them to make informed choices. Included is information about the eligibility requirements for Medicare; selection and enrollment in a Medicare prescription drug plan; benefits covered (and not covered) by the program; the payment process; the rights of beneficiaries; the process for determinations, coverage denials and appeals; consumer safeguards; and options for filling the gap in Medicare coverage. These programs also provide counseling and assistance about the subsidies that are available to low income beneficiaries enrolled in the Part D Prescription Drug Benefit; and may also provide information about Medicaid and the linkages between the two programs, referrals to appropriate state and local agencies involved in the Medicaid program, information about other Medicare-related entities (such as peer review organizations, Medicare-approved prescription drug plans, fiscal intermediaries and carriers), and assistance in completing Medicare insurance forms.

USE TERM(S):
LIS Information/Counseling, Medicare Counseling, Medicare Part D Information, Medicare Part D Low Income Subsidy Information/Counseling, Part D

MEDICARE PRESCRIPTION DRUG PLAN ENROLLMENT (NS-8000.5000-660)

Medicare Prescription Drug Plans that are approved by the Centers for Medicare & Medicaid Services (CMS) to offer prescription drug coverage and accept applications for enrollment from Medicare beneficiaries. Beneficiaries may also enroll in a plan through the online enrollment application available on the CMS website which also has a tool for comparing different plans.

CERTIFICATES/FORMS ASSISTANCE (FT-1020)

Programs that help people obtain, complete and/or file official forms, certificates, documents, applications or other paperwork that is required to apply for benefits or services, initiate or respond to legal action or to officially handle or document the occurrence of a transaction; that help people acquire copies of official documents on file elsewhere; or that review legal documentation an individual has received to help explain its meaning.

* MEDICARE BENEFICIARIES (YC-5100)

Individuals, age 65 and older or younger than age 65 with a disability, who have hospital, medical and prescription drug insurance through the federally-funded Medicare program.

MEDIGAP COUNSELING (LH-3000.5000)

Organizations that offer insurance policies which pay for some health care costs that are not covered by Medicare. These generally include Medicare deductibles and co-payments, but not long-term care.

MEDICARE PART D LOW INCOME SUBSIDY APPLICATIONS (NS-8000.5000-600)

Social Security offices that accept applications and determine eligibility for the subsidies that are available to low income beneficiaries enrolled in the Medicare Part D Prescription Drug Benefit. Beneficiaries may also apply for the subsidy through the online application available on the Social Security Administration website.

USE TERM(S):
LIS Applications, Medicare Part D Prescription Drug Subsidy Applications, MIPPA

MEDICARE SAVINGS PROGRAMS (NL-5000.5000-700)

Programs that pay all or a portion of Medicare costs for low income Medicare beneficiaries with limited resources/assets. The programs are administered by Medicaid medical assistance offices, pay all or a portion of Medicare premiums and may pay Medicare deductibles and co-insurance. Included are the Qualified Medicare Beneficiary (QMB) program that pays Medicare premiums, deductibles and co-payments for people with combined incomes that do not exceed 100 percent of the federal poverty level; the Specified Low-Income Beneficiary (SLMB) program that pays Medicare Part B premiums for people with combined incomes between 100 and 120 percent of the federal poverty level; and the Qualifying Individuals (QI) program that pays Medicare Part B premiums for people with combined incomes 120 and 135 percent of the federal poverty level. The QI program is available on a first come, first served basis. The asset/resource limit is uniform across all programs and is $4000 in countable assets/resources for individuals and $6000 for couples.

USE TERM(S):

APPENDIX L

Dual Eligibles Programs, Medicaid Administered Medicare Savings Programs, Medicare Premium Expense Assistance, MIPPA, MSP, QI Program, QMB, QMB Program, Qualified Medical Beneficiary Program, Qualifying Individuals Program, SLMB, SLMB Program, Specified Low Income Beneficiary Program

MEDICARE FRAUD REPORTING (FN-1700.3350-550)

Programs that provide a hotline or other mechanisms that persons with Medicare and the public at large can use to report health care providers or beneficiaries who make false statements or representations which result in an unauthorized payment by the Medicare program to themselves or another. Also included are organizations that accept and investigate reports about fraudulent entities that misrepresent themselves as approved Medicare Part D Prescription Drug Plans; approved plans that use aggressive marketing tactics, discriminate against a beneficiary (e.g., prevent them from signing up for a plan based on their age, health status, race or income), entice beneficiaries to enroll in a more costly plan than they require, or erroneously charge beneficiaries for medication provided under the plan they have selected; or pharmacies that provide a different drug than the one prescribed by the physician. Examples of Medicare fraud include incorrect reporting of diagnoses or procedures to maximize payments; billing for services, medical supplies, equipment or medications not provided; misrepresentation of the dates and descriptions of services or medications provided, the identity of the recipient or the individual furnishing services; and billing for noncovered or nonchargeable services as covered items. Also included are programs that provide consumer education, counseling and assistance with the objective of helping people identify instances of fraud.

USE TERM(S):
Prescription Drug Plan Fraud Reporting, SMP, SMP one on one Counseling

Senior Medicare Patrol – SMP

Simple Inquiries – Quick, basic information calls, with no or little research needed, and no need for callers' PHI (Protected Health Information)

- Save Site Reason SMP within ServiceLink listing.

One on One Counseling or Education – Call or contact where more research, specific information, PHI, education and individual assistance is provided on a complaint or question about a suspicious billing error (e.g. excessive charges an unrecognized provider name, or an x-ray interpretation billed ona Medicare Summary Notice).

- Use one of the taxonomy terms **Fraud Prevention*Medicare Beneficiaries** or **Medicare Fraud Reporting** to document 1:1 counseling. Note that this a national taxonomy term and both are used so that the general public can find us on the public website.

- Save the referral to your ServiceLink office

Complex Issues – When working on and/or referring an SMP contact or call that develops into a complex issue that requires research and further investigation by **another agency.**

- Mark a referral to ServiceLink using the taxonomy term **Medicare Complex Issue Fraud Reporting**

  o Gather pertinent documents, MSN & consumer signed release form

  o Complete Complex Issue form

  o Fax to Becky Rostron at 542-2640. If unsure contact Becky or Karol

How to add time

If you forget to have a call open the whole time you are doing the above work, do the steps below to add time.

- You can add time either while in a "live call" or in standby mode
- From the Pg. 2 People page, Go to the Client Activity and Notes page
- On the left, select the contact you want to add time to – click on the blue part.
- Click on the "Review" tab

- Add the time you put into the contact and/or change the date, then click "Save" and you're done!

Appendix E: Refer 7 VIP Program Tip Sheet

Refer7	Content	Who should use/who sees	When to use
Page 3. Contact Marker	Mark based on type of contact you had.	Staff person doing VIP	Use the contact marker that matches the type of contact you're having (phone, office visit, etc)
Page 2. Contact Person Type	Mark based on type that best fits the contact person	Staff person doing VIP	Select the contact person type that best fits and reflects the contact person at the time of contact.
Client Data	Information pertaining to referral source for Options Counseling/VIP, house hold make up, marital status, legal documents and arrangements**, Mark as much information as you have, as more becomes available or if things change, add and edit.**	Staff person doing VIP	On "Edit Client" page, complete as many Client Data fields as you can. Especially for those receiving Options Counseling/VIP.
Client Marker	Use when one of the client markers matches the consumer's situation. **Veteran or Veteran Directed HCBS Program**	Staff person doing VIP	Use when the client marker matches the consumer's situation. If Veteran is participating in VIP use both markers.
Associated People	Add caregiver if applicaple as an Associated Person. Search to see if they exist, select or add new and save appropriate relationship.	Staff person doing VIP	When providing Options Counseling/VIP Counseling and needing to connect VIP partcipant to caregiver.
Reason for Call	Choose base on Type of information provided	Staff person doing VIP	Use when providing Information and documenting what matches what is provided during the contact.
Referral **It is important to note that these referrals are tied to NH VDHCBS program work. If the staff doing this work also provide Person Centered Options Counseling, SHIP, Caregiver support etc. Other documentation and processes also apply.**	SLRC Program Name New Hampshire Veterans Directed Home and Community Based Care Program: *Taxonomy term: Home/Communty Care Financing Programs*Veterans For all other types of services provided such as options counseling, certificates/forms assistance, etc. You will mark those within Options counseling, or other Service group/program within **Use Terms: When searching in Refer type in VIP, VDHCBS, Veteran**	Staff person doing VIP	Used when completing an assessment, plan, budget, review, or amendment for VIP.

Follow Up **May be streamlined meaning most of these would be eliminated.**	1. When scheduling appointments, future assessments, quality reviews with VIP participant 2. *Other general follow up reasons as needed. Email reminder, schedule home visit or office visit, mail information reminder, etc.	Staff person doing VIP Everyone	1. Counseling appointments/check-ins to assess for changes and updates to VIP plan and person centered plan. 2. When reminding or scheduling activity for a future date as a result of a contact.

Appendix F: Health Insurance Marketplace

Effective : 1/1/14 updated 1/27/15

Refer7	Content	When to use
Documenting a contact **Transfer, follow up, unmet needs, client notes**	1. Contact Marker: Call, office appointment, community visit, walk-in, email, fax, etc. 2. Under ServiceLink agency, Program name: Health Insurance Market Place Assistance Program, <u>Taxonomy Term:</u> **In Person Assister Program** **AKA/Use Terms: Health Insurance Marketplace, Marketplace, ACA, Assister.**	1. MPA staff will mark Contact Marker that accurately reflects how MPA occurred. (Call, office appointment, community appointment, email, etc.) 2. Used when SLRC team member refers to or provides Assister Program functions. Note: If a MPA is providing information, assistance, and/or access to the Marketplace in NH they will select this term. Note: can differentiate referrals and activity by staff person attached to referral. Documentation related to coordinating, and recording is left to the judgment of the MPA. If person in anonymous these other functions are most likely not going to be used in the Refer system.
Client Markers	Health Insurance Market Place	When a client is entered and is calling or getting assistance on HIMP.
Special Circumstances:		
Client Data and Demographics	Contact name/client name: **Anonymous** Additional Client Demographics: **gender** **zip code** **age range**	No personal information will be documented as an MPA client. Client name will be entered as anonymous. Because of this each session/instance an MPA meets or speaks to an individual on MPA it will be entered as a new person.
If an MPA client becomes a ServiceLink client. **Or** **If a ServiceLink client becomes an MPA client**	MPA will find out if the person wants ServiceLink staff to follow up with them and will make referral if appropriate. ServiceLink will make clear that personal information could be available to the MPA under the ServiceLink Umbrella.	MPA will make clear to the client when his personal information is being stored and when it is not. Client can choose to remain anonymous in terms of MPA and the ServiceLink and MPA staff would respect the decision of the client. The client would be entered as a new anonymous person.

Taxonomy Definitions

APPENDIX L

Service Group: **AFFORDABLE CARE ACT INFORMATION/COUNSELING**

IN PERSON ASSISTER PROGRAMS (LH-3500.0200-330) Programs permitted by the Affordable Care Act (ACA) that provide in-person assistance personnel (also known as non-navigator assistance personnel) to help people understand and access insurance coverage through the marketplace. In a state-based marketplace, in-person assistance personnel may serve as a part of an optional, transitional program that the state can set up before its marketplace is economically self-sustaining, and before its navigator program is fully functional. Though they perform the same functions as navigators, in-person assistance personnel are funded through separate grants or contracts administered by a state. In person assistance personnel must also complete comprehensive training.

Refer7	Content	Who should use/who sees	When to use
Referral or reasons for call to you or your ServiceLink and or another ServiceLink **Health Insurance Market Place (HIMP)** **NOTE: # 6 is not on the public searchable website yet. Only staff can see and use this at this time.**	3. SLRC Program Name Options Counseling, *Taxonomy term: **State Medicaid Managed Care Enrollment Programs** 4. 2. SLRC * Taxonomy Term: Managed,Health Care Information 5. Taxonomy term: **Medicaid Information Counseling** 6. BEAS state office for Choices for Independence *Taxonomy term: **State Medicaid Waiver Programs** 7. Taxonomy Term: **Certificates/Forms Assistance*Medicaid** referral to your SLRC 8. Under ServiceLink agency, Program name: Health Insurance Market Place Assistance Program, Taxonomy Term: **In Person Assister Program** **Use Terms: Health Insurance Marketplace, Marketplace, ACA, Assister.** 9. Contact Marker: Contact Marker: Call, office appointment, community visit, walk-in, email, fax, etc. 10. Client Name Rule for: Anonymous Note: can differentiate referrals and activity by staff person attached to referral. 11. For Information Use Reason for call: **New Hampshire Health Protection Program Information** 12. For referral for	1. Everyone 2. Everyone 3. Everyone 4. Everyone 5. Everyone 6. Everyone 7. Everyone 8. MPA Staff 9. Everyone 10. Everyone 11. See #3	1. Used by SLRC team when making a referral to MCM Call Center for Enrollment and or SLRC team **when assisting with MCM Enrollment.** 2. Used by staff **providing information and guidance** regarding available managed health care options 3. Use when SLRC team member refers or provides information, screening, guidance, and/or assistance for people who may qualify or receive Medicaid 4. Used when referring individuals to CFI or NF Medicaid and/or when entering app in New Heights 5. Used when assisting in completing an enrollment form for managed care, form 800 and/or when entering CFI or NF Form 800 in New Heights 6. Used when SLRC team member refers to or provides Assister Program functions. Note: If a MPA is providing information, assistance, and/or access to the Marketplace in NH they will select this term. 7. Staff will mark Contact Marker that accurately reflects how contact occurred. (Call, office appointment, community appointment, email, etc.) 8. Contacts and Clients being assisted by MPA staff will be entered as **ANONYMOUS** 9. Contacts and Clients being assisted by ServiceLink who need information or explanation about NHHPP. 10. When you refer someone to NH

Appendix L

APPENDIX L

NH Health Protection Program (NHHPP)	Applications use Program Name: **NH Health Protection Program** and Taxonomy Term: **Medicaid Applications** Use Term NHHPP 13. For referrals for to self for counseling, enrollment assistance, **see #3**		EASY, Division of Client Services, for applying for the NHHPP. 11. See #
Client Markers	Health Insurance Market Place	MPA Staff	When a client is entered who is calling or getting assistance on HIMP.
Client Data and Demographics	Information pertaining to referral source, house hold make up, Insurance, marital status, legal documents and arrangements, **Mark as much information as you have, as more becomes available or if things change, add and edit.**	Everyone	On "Edit Client" page, complete as many Client Data fields as you can. Especially for those receiving Options Counseling.

Taxonomy Definitions
STATE MEDICAID MANAGED CARE ENROLLMENT PROGRAMS (NL-5000.5000-770)

State programs (or private vendors under contract with the state) that enroll Medicaid recipients in a Medicaid managed care program that coordinates the provision, quality and cost of care for its enrolled members. Recipients may have a designated amount of time to choose a managed care option following eligibility determination; and once enrolled, select a primary care practitioner from the plan's network of professionals and hospitals who will be responsible for coordinating their health care and referring them to specialists or other health care providers as necessary. In some situations, where acute and primary care are not integrated into the selected option, people may work with a multidisciplinary team of professionals to support service plan development and implementation. Enrollment in a managed care plan may be voluntary or mandatory for some or all Medicaid recipients in a state. Participation requirements and associated criteria vary from state to state and in some cases, from area to area within the same state. States often make exceptions to their mandatory enrollment requirements for certain individuals and groups, e.g., people with disabilities or identified health conditions, who may be served outside the state's managed care delivery system. These individuals may enroll in a managed care program but are not required to do so. States may also identify a range of Medicaid eligibility groups who are excluded from participating in their managed care programs.

MANAGED HEALTH CARE INFORMATION (LH-3500.4800)

Programs that provide information and guidance regarding available managed health care options with the objective of helping people become more knowledgeable health care consumers. Managed health care deals with the variety of methods for financing and organizing the delivery of health services in which costs are contained by controlling the provision of services.

12/1/1512/1/15Search and Referrals Module   Version 3.0 **Refer Training**   163
Page 168 of 193

MEDICAID INFORMATION/COUNSELING (LH-3500.4900)

Programs that offer information and guidance for people who may qualify for Medicaid including those who do not have access to insurance provided by an employer, cannot afford privately purchased health insurance or cannot afford the out-of-pocket costs associated with a health insurance plan they may have in place with the objective of empowering them to make informed choices. Included may be information about the eligibility requirements for Medicaid and how to apply; Medicaid Managed Care options including benefits covered (and not covered) by the program; the payment process for co-payments; Medicaid "spend-down" (the process of reducing the assets an individual possesses in order to qualify for Medicaid); and information about Medicare and the linkages between the two programs. The program may also answer questions about Medicaid services available to individuals with disabilities; and some programs may help people who qualify with enrollment and provide referrals to providers who accept State Medicaid health insurance.

Service Group: AFFORDABLE CARE ACT INFORMATION/COUNSELING

IN PERSON ASSISTER PROGRAMS (LH-3500.0200-330)

Programs permitted by the Affordable Care Act (ACA) that provide in-person assistance personnel (also known as non-navigator assistance personnel) to help people understand and access insurance coverage through the marketplace. In a state-based marketplace, in-person assistance personnel may serve as a part of an optional, transitional program that the state can set up before its marketplace is economically self-sustaining, and before its navigator program is fully functional. Though they perform the same functions as navigators, in-person assistance personnel are funded through separate grants or contracts administered by a state. In person assistance personnel must also complete comprehensive training.

Appendix H: Common Taxonomy Terms

The following table can be used to figure out which term is most appropriate to use to log a referral. There are many other terms for many other agencies and services, however these are some of the most common. Staff are encouraged to submit ideas for additions to this section as needs of consumers and the nature of staff member's work changes. Please note that the taxonomy is an ever-changing collection of terms that are updated frequently and are subject to change.

If looking for:	Search by: (Taxonomy Term)
TRANSPORTATION	Local Transportation
	Medical Transportation (note this term is in transition to Medical Appointments Transportation. During transition both terms should be searched)
	Disability Related Transportation
	Paratransit Programs
	Local Bus Services
IN HOME ASSISTANCE	Homemaker Assistance
	In Home Meal Preparation
	Personal Care
	Friendly Visiting (also use Companionship)
HOME NURSING (medical care)	Home Nursing
	Home Health Aides
	Home Health Care
PRESCRIPTION ASSISTANCE (for those not on Part D, or those who are in donut hole)	Prescription Drug Patient Assistance Programs
	Prescription Expense Assistance
	Prescription Drug Discount Cards
CITY/TOWN WELFARE	Electric Bill Payment Assistance
	Food Vouchers
	Gas Bill Payment Assistance
	Medical Expense Assistance
	Rent Payment Assistance
	Telephone Bill Payment Assistance
	Temporary Financial Aid
	Prescription Expense Assistance

APPENDIX L

If looking for:	Search by:
MEDICARE	Medicare Enrollment
	Medicare Information/Counseling
	Medicare Fraud Reporting
	Medicare Insurance Supplements
	Medicare Savings Programs (QMB/SLMB)
MEDICARE PART D	Medicare Prescription Drug Plan Enrollment
	Medicare Part D Low Income Subsidy Applications
	Medicare Information/Counseling
HOUSING	Housing Authorities
	Low Income/Subsidized Rental Housing
	Low Income/Subsidized Private Rental Housing
	Independent Living Communities/Complex*Older Adults
	Older Adult/Disability Related Supportive Housing
	Shared Housing Facilities
ASSISTED LIVING OR NURSING FACILITIES	Nursing Facilities
	Skilled Nursing Facilities
	Assisted Living Facilities

Appendix I: Client vs Contact: Which is which?
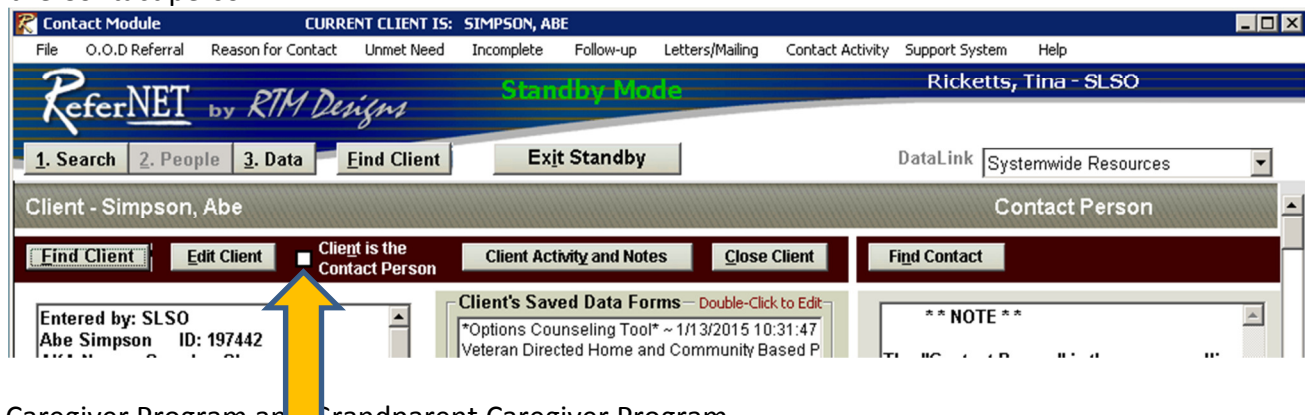
The majority of ServiceLink interactions or "calls" with consumers will follow the basic model of categorizing the people with which you interact. There is however an exception to the rule and that is for the NH Family Caregiver and Grandparent Caregiver Programs. For consistent reporting methods it is important that calls are logged appropriately.
Most calls:

> Client – The person who needs a service such as information, assistance, financial resources etc.

> Contact – The person you are actually talking to. If you are working with a social worker, the worker is the contact, their client is the Client.
> If the person you are talking to **IS** the person in need of services, then the Client is the Contact person.

NH Family Caregiver Program and Grandparent Caregiver Program
> Client – The Caregiver
> Contact – The Care Receiver
> Note: If the information for Client and Contact people is completed then much of the info will be automatically populated in the correct fields in the Data Forms found on Tab 3.
Data. It is important to note however, that not all information is populated so the remainder of the information will still need to be completed for proper federal reporting.

Associating People

In order to link the client and contact person you will first search for each of the names using either Find Client (for the Client) or Find Contact (for the Contact)

Associate the client and contact by clicking on the **Add New** button in the **People Associated to this Client** section at the bottom of the center column on Page 2. People. A pop up will display asking if you want to as

Appendix J: ServiceLink Disclaimer

The agencies on this list are intended to be used for referral purposes only. We do not license or otherwise regulate, endorse or recommend any provider. Our referral protocols require us to provide information about all available providers in a service area in an impartial manner based on consumer need and request.   This information is accurate to the best of our knowledge. The ServiceLink/ServiceLink Resource Center network is not responsible for errors in the information we provide about providers.

What to Say When a Provider Requests a Change/Addition to Agency Information

Our resource database is statewide, and is managed centrally. We have forms on the ServiceLink website that you can fill in and submit to our resource manager. To get to these forms, go to http://www.servicelink.nh.gov/, and in the column on the left you will see "Provider Tools". Click on this to take you to a page with links to several documents for adding or changing information. It also has our Inclusion/Exclusion policy that governs decisions about adding agencies.

Appendix K: Harder to Reach Consumers of Long-Term Supports

We grouped populations into the following four categories based on what makes them "hard to reach."

Population	Why Harder to Reach
1. People who are physically homebound or isolated (including elderly caregivers and those without phones)	Limited access to information. Get mostly from what comes into the residence via mail, radio, television, housemates and visitors/caregivers
2. People who need someone to assist them with reading and/or comprehension of written information such as those who: • are cognitively impaired; • have trouble understanding written information provided and benefit from guidance about what to do with information; • are not literate; • cannot physically hold printed material before themselves to read; • do not read and/or speak English	Most information provided in print or visual formats will not be understood or will not reach without the involvement of another to assist or translate.
3. People with sensory disabilities such as those who are hearing or visually impaired	• Can't receive oral instructions from member services, information and referral lines, television or radio unless information is transmitted using a TTY/TDD device, or • Can't read without Braille translations
4. People who are elderly or who have chronic illnesses or conditions whom may need long-term supports in the future but who decline information because they don't feel it's relevant now.	Will not read materials provided or be engaged by, nor attend, events that provide information about long-term supports
5. Minorities	Will not necessarily accept/absorb the printed materials delivered in the typical manner. Message content and delivery mechanisms may need to be modified for different groups to be sensitive to different minority groups' preferences for how they hear and process information.

Appendix L: Reports Module

Creating a wide variety of statistical reports is easy. Users can create one-, two-, or three- level reports using any report items found in the database.
1. Service Reports
2. Call & Client Marker Reports
3. Call & Client Data Sheet Reports
4. Client Reports
5. Staff and Time Reports
6. Follow-Up Reports

Creating reports is an easy process.
1. On the dashboard page, click on Tools→Contact Reports
2. Verify that your SL office is selected from the Access Sites in the bottom left corner
3. Set the Date Range for the report.
4. Select the Report criteria from the "Select Report Items" list.
5. Click **Run Report.**

Creating reports is easy, but you may want to work in the module to see what the reports look like. Here is an example:

Perhaps you need a report of all Service Referrals for the past month. You only want info for Cheshire and Sullivan Counties and you want to all referrals, unmet needs, and reasons for contact, additionally you want to know what targets were utilized.
To create this report:
1. Enter the date range for the report.
2. Select "Search Option – County" from the "Select Report Items" list.
3. Select "Referred, Unmet Services, Reason for Contact" from the list.
4. Select "Referred Targets" from the list.
5. Enter a title for the report if you want to change it.

6. Click the **Run Report** button.

You may print the report from this screen (the printer icon button at the top), or you can export the report in three different formats. If you export it, you may retrieve it from your RTM file download site (more in the export section of the manual).

Reading the Report

Though it may seem straightforward, interpreting the report can be tricky for those who do not know what they are looking at. It is important for those running the report and those reading the report to understand how the report is constructed. Beginning at the top of the report you can see the name of the organization that put together the report, the search items selected, the date range and then in smaller print, the total number of calls that this report is pulling from.

Utilizing the screenshot and the example report from above you can see that there were 1817 total calls (or contacts) for that date range. Of the 1817 total calls, 999 of them came from Cheshire County. Of the 999 calls from Cheshire County 47 were for Certificates/Forms Assistance. Of the 47 calls for Certificates/Forms Assistance, 7 were for Medicare Beneficiaries, 4 for Low Income and 2 for Medicaid Recipients.

It is important to understand that the database will only pull the next item from the list based on the subset of data from the previous item. In the example above there are only 7 Medicaid Recipients listed. That does not mean that there were only 7 Medicaid Recipients calling overall, just that there were 7 Medicaid Recipients that needed Certificates/Forms Assistance. If

you needed to know the overall number of Medicaid Recipients in Cheshire County, that would be a different report.

Enhancing the Report
Some reports don't require all data for the data range, only selected items. To select specific report items, click the items from the displayed lists. To select more than one option you can hold down the Ctrl button on your keyboard and make multiple selections. If you want to select a whole range of items hold down the Shift key and select the top and bottom item from the list, all the items in between will be selected.

Saving and Selecting Report Formats
Report selections can be saved so the user doesn't have to reselect the report items each time to run the report. The selections are saved with a title and this title is added to the "User-Defined" list. The report title can be selected for future use. The report display may also be customized with the available checkboxes below each report selection to either display or not display the items below:
1. Show % - Displays the percent of occurrences of the selected item.
2. Show Count - Displays the count of occurrences of the selected item.
3. Show Total - Displays the total of the column for the selected item.
4. Show Breakout - When a multiple action item is selected (example: Referred and Unmet Services), the breakout option displays whether the item is a referral or and unmet need.
Save a Report Format:
1. Select the items for the report.
2. Click the **Save** button.
3. Enter a title for the report.
4. Click the **Save Report Name** button.
Selecting a Saved Format:
1. Select a Report Type.
2. Click the **See Saved Reports** button.
3. Double-click a report format from the list.

Creating Saved Report
Set your data Range
Select the Report Items
Click the Save Button This prompt will appear

Name the Report
Click Save Report Name
Click Run Report
The Report Preview Screen will appear
You can print the report or export the report
If you are exporting select the format (PDF., RTF, Text or Excel)
Then Name the report so it is easily identified in your download folder.

Appendix M: NH CarePath Referral Form
Draft Version 6/29/15

The NH CarePath Referral form is an optional tool to assist you in making referrals to the CarePath partners. It collects all of the information that the partner will need to begin working with a client. The form can be located in the bottom left-hand corner of the Page or Tab 3 Data. It is important to note that you will need to have an active client before accessing the form because some of the information is pre-populated and unable to be edited.

*Note, at this time the window is an inconvenient size but is scrollable. I have addressed the window size and it will be fixed in the future.

Below you will find a screenshot of the top of the referral form. I have marked, with stars, the fields that are pre-populated. Note that if any changes need to be made to the fields marked with a star you will have to edit those in the client info screens (in Tab 2 People, click on Edit Client).

To:	From:
Type ○DCS DHHS ○Area Agency ○CMHC ○SLRC	Type ○DCS DHHS ○Area Agency ○CMHC ○SLRC
Reasons for referral/Present Situation:	

★Client Name: Abe Simpson   ★Client DOB: 10/15/1936

Who is contact person for this client? ○Self ○Other _____

★Address: 1234 Evergreen Terrace Springfield, NH 03284   ★Cell: (603) 554-4444

★Phone: (603) 555-5555   ★Other: (603) 553-3333

Where can we leave a message with the client? _____

What is your clients current living situation? ○Homeless/Shelter ○Independent Living ○Group Home/Assisted Living

★Number in the home: ____   Do they have access to transportation? ○Yes ○No   If yes, what kind? _____

Below is a screenshot of the area in which you can edit the information marked by a star. Note, if you enter the word "Cell" or "Other" in the notes section of the phone number, it will populate those numbers into the Referral form.

The next section of the form should be completed to indicate why you are making the referral, what are the reasons that you believe the person is qualified for the program to which you are referring them. The questions in this section are designed to address Activities of Daily Living (ADLs) as well as Instrumental ADLs and Cognitive Functioning. In each section you may check off as many options as apply to the client. There is also a section to enter notes for any concerns you may have that are not addressed by the questions asked previously or to include other pertinent information.

Check All That Apply

Activities of Daily Living: ☐ Eating ☐ Bathing ☐ Dressing ☐ Grooming/Hygiene ☐ Toileting ☐ Mobility (in home and/or out of home) ☐ Positioning ☐ Transferring ☐ Communicating

Instrumental Activities of Daily Living: ☐ Preparing Meals ☐ Shopping ☐ Transportation ☐ Housework ☐ Managing Money ☐ Telephone Use ☐ Employment ☐ Medication Management

Any of the Following: ☐ Cognitive Function ☐ Memory Concerns ☐ Communication ☐ Sensory or Motor Disablilty ☐ Learning Concerns ☐ Judgment and Decision Making Issues ☐ Behavioral Health Concerns ☐ Other: _____

Please list any additional attachments or forms you are sending with this referral: ☐ Level One Screen ☐ 800 Application

☐ Agency Assessment _____

☐ Other:

_____

List any additional information the client would like to share:

[text box]

The last section of the form is the acknowledgement section. It is a section that allows the client to review the information in the form that you are going to submit and provide authorization to release the information to the agency to which they are being referred. The authorization is good for one year.

THIS AUTHORIZATION IS VALID FOR ONE YEAR AND MAY BE REVOKED AT ANY TIME IN WRITING PRIOR TO THE EXPIRATION DATE, EXCEPT TO THE EXTE
AGENCY HAS ALREADY USED OR DISCLOSED THE INFORMATION IN RELIANCE ON MY AUTHORIZATION.

I UNDERSTAND THAT THE ORGANIZATION I AM RELEASING INFORMATION TO WILL NOT CONDITION TREATMENT ON MY PROVIDING THIS AUTHORIZATIO
MAY REFUSE TO SIGN THIS AUTHORIZATION, UNLESS THE TREATMENT INVOLVES RESEARCH, OR IS PERFORMED ONLY FOR THE PURPOSE OF CREATING F
HEALTH INFORMATION FOR DISCLOSURE TO A THIRD PARTY (SUCH AS INSURANCE PHYSICALS).

I understand that the recipient of information disclosed under this authorization may re-disclose this information, and the information may be protected by federal or state confidentiality

I understand that NH law permits the organization I am signing this form for to charge for the cost of copying the information released under this authorization, up to $15 for the first 30
page, whichever is greater. (NH RSA 332-I:1)

Patient / Legal Guardian Signature _____   Date _____

RELEASE OF SENSITIVE INFORMATION

I UNDERSTAND THAT MY RECORD MAY CONTAIN SOME INFORMATION IN REFERENCE TO, BUT IS NOT LIMITED TO, DRUG AND/OR ALCOHOL ABUSE, PSYC
TREATMENT, VENEREAL DISEASE, HIV/AIDS TESTING/INFORMATION, HEPATITIS B TESTING OR TREATMENT.

Patient / Legal Guardian Signature _____   Date _____

Submit Form

The form must be submitted before you can print or export it. Click on the Submit button then other buttons with other options will appear.

Appendix N: NH Care Path Level 1 Screening Tool Info Sheet
Draft Version 6/29/15

The Level One Screening Tool is intended to determine a person's likely eligibility for Medicaid Funded Long-Term Community- Based Services and Supports. In addition to Medicaid services and supports, the screening tool will help identify a full-spectrum of options based on an individual's needs and goals. The information that a person shares in this questionnaire is confidential and will only be shared with other agencies with the person's permission.
The Level 1 Screening Tool can be found on Page or Tab 3 Data, in the lower left-hand box, in the same area that the SHIP form and the Caregiver forms.
Nothing is prepopulated on this form, but all of the questions necessary to perform the screening are listed on the form with buttons available to click for each of the answers.
Section 1 covers the client's basic needs, and Section 2 covers financial information. It is important to make sure and ask each of the questions and provide the answer on the form.

Section 1: Basic Needs Questions

Q1   **Who are you seeking or care for?**

        ☐ Myself ☐ Sibling ☐ Other Family Member

        ☐ Parent ☐ Friend

        ☐ Child ☐ Spouse

Q2   **What is your (or the person you are inquiring about) date of birth?**

Q3   **What town do you (or the person you are inquiring about) live in?**

Q4   **Have you ever served in the Military?**

        ☐ Yes ☐ No

Q5   **Do you (or the person you are inquiring about) have a medical or physical condition that resu assistance with two or more activities such as getting in and out of bed, dressing and bathing, managing medications, or using the toilet, etc.?**

        ☐ Yes

        ☐ No

Q6   **Do you (or the person you are inquiring about) have, or think you may have, a mental health difficult for you to concentrate or complete your daily tasks?**

        ☐ Yes

☐ No

Q7   **Do you (or the person you are inquiring about) have or think you might have an intellectual d**
epilepsy, autism or a specific learning disability, or any other condition closely related to an ir

☐ Yes

☐ No

Q8   **Have you (or the person you are inquiring about) experienced an injury to the brain as a resul**
injury; lack of oxygen to the brain following surgery, a near drowning, a heart attack, stroke, (
to toxic substances; a disease or disorder that affects the brain; a brain tumor; or other traum

☐ Yes

☐ No

Q9   **What are your (or the person you are inquiring about) most pressing needs?**

☐ Help managing my care

☐ Help with personal care such as getting in and out of bed, bathing, dressing, eating, etc.

☐ Someone to visit me at home

☐ End of life care/hospice

☐ Information on how to better manage my daily routines such as household chores, preparing

☐ Modification to help me stay in my home such as ramps, grab bars, bathroom and other moc

☐ Mental health support

☐ Help with alcohol, drug, or other substance dependency

☐ Taking medication at prescribed times

☐ Filling & picking up medications

☐ Help me improve my ability to move around my home and community (Physical Therapy)

☐ Help with speech and language concerns (Speech Therapy)

☐ Financial assistance to fill my prescriptions

☐ How to get a short break from my caregiver responsibilities

☐ Nursing care for wound care, tube feeding, nurse oversight, etc.

Other:

SECTION 2: Financial Questions (complete the following section OR go to
www.nheasy.nh.gov to determine financial eligibility)

APPENDIX L

Q10   **At this time, are your resources (bank accounts, personal property, retirement account, etc.) individual or $4,000 for a couple?**

    ☐ Yes

    ☐ No

APPENDIX L

Q11 **What is/are your (or the person you are inquiring about) insurance resources?**

☐ Long term care

☐ Medicaid

☐ Medicare

☐ Pay for services myself or with family help

☐ Private Insurance

☐ Social security disability insurance (SSDI)

☐ TriCare

☐ Veterans Administration

☐ None

☐ Other:

APPENDIX L

Appendix O: Inclusion/Exclusion Policy and Unmet Need

The ServiceLink Resource Center (SLRC) envisions communities that empower and support citizens to make the personal decisions, plans, and social connections that allow them to live as independently and fully as possible.

New Hampshire (NH) SLRC program is a network of community-based sites with the common purpose of providing information, referrals, and assistance to connect older adults, adults living with disabilities, their families and caregivers with resources in their communities. The purpose of the Resource Database is to maintain one information system that includes non-partisan, non-ideological information about the range of long term supports and resources in the State of NH.

The intent of this policy is to standardize the criteria that SLRC staff will uniformly apply in order to qualify or disqualify an agency, organization, or program from inclusion on the Resource Database. The policy will ensure database consistency, streamline the decision-making process as it relates to inclusion or exclusion on the database; and provide objective evidence to support decisions that may be protested, either by agencies that object that they have been excluded or by individuals or organizations that object to a particular organization being included on the Resource Database.

The following criteria will be applied to determine which agency services may be included or excluded in the Resource Database. The criteria are based on the *AIRS Standards for Professional Information & Referral and Quality Indicators*, Version 6.0, revised January 2009 and published by the Alliance of Information and Referral Systems.

Inclusion Criteria:

To be included on the Resource Database the following criteria will be met:

1) The agency will offer one of the following services: health, social service, consumer focus, educational, and/or environmental;
2) The agency will have existed for at least three months; and
3) The agency will have proof of licensure as required by regulating agencies.

The agency will also fall into one of the following categories:

1) <u>Non Profit</u>
   a) Private, non-profit 501 (c)(3) organizations that offer free low cost services to the community at large (not just to members)
2) <u>Government</u>
   a) Government (local, state, federal) and quasi-public agencies
   b) Note: No attempt will be made to list all government agencies and departments

3) Non Profit or Government
   a) Crisis lines, hotlines, help lines, information lines, and information and referral lines administered by non-profit organizations or government entities
   b) Local, statewide, and nationwide toll-free phone services that can be accessed by callers in New Hampshire; that provide a socially beneficial service (health, social, consumer focus, educational, and/or environmental services); and that are administered by government or nonprofit organizations
4) Community/Support Groups
   a) Self-help support groups that do not charge a fee or charge a nominal fee (include state, regional, or national headquarters to enable tracking of local support groups that may frequently change contacts or sites)
   b) Advocacy groups and community coalitions/clubs, on a limited basis, concerned with health and human care issues
5) For Profit/Proprietary
   a) For profits providing affordable health and social services not adequately met by other resource listings; or offering free service(s), scholarships, reduced fees, a sliding fee scale, or that accept Medicaid
   b) For profits that accept court diversion requirements
   c) For profits that provide unique, specifically targeted services, or services that are otherwise difficult to access, e.g., serve an area where resources are scarce
6) Non Profit, Government, Community Based Organization, For Profit/Proprietary
   a) Acute care hospitals
   b) Community clinics
   c) Organizations that are designated, funded, or contracted by the government to provide specific social services (a Medicaid contract does not meet this qualification)
   d) Professional associations providing a public service, e.g., information and referral
   e) Organizations located in states adjacent to New Hampshire that meet all inclusion criteria

Exclusion Criteria

Agencies that meet the following criteria will be excluded from the Resource Database:

1) Non Profit
   b) Churches that offer no special services to the community at large
2) Government
   c) Candidates for public office and elected government officials
3) Community/Support Groups

     d) Local service groups (Rotary, Jaycees, etc.) that offer no special services to the community at large

4) <u>For Profit/Proprietary</u>

     a) Private practitioners such as: group practices of mental health providers, medical doctors, osteopaths, podiatrists, dentists, legal/paralegal providers, etc., unless the practitioner is affiliated with a large, well-known national company or organization, or the private practitioners are providing a unique, much needed service is provided in the community; for example, the practitioner is the only dentist in town whose location is wheelchair accessible

     b) "Support groups" offered by private therapists or social workers for which there is a fee to pay the leader for his/her time

     c) Organizations that provide free services when their primary purpose is to market the organization's main business. For example, a condo company providing free airfare to Florida, as long as one attends a seminar to purchase condo housing

     d) Providers that are not established or temporary in nature may be declined for acceptance

     e) Other for profit organizations that do not meet the inclusion criteria

5) <u>Non Profit, Government, Community Based Organization, Corporation (or any agency/organization) that</u>;

     a) Denies service on the basis of race, sexual orientation, religious beliefs, or national origin; or that violate local, state, or federal laws or regulations

     b) Upon request, does not supply proper documentation, e.g., proof of 501 (c) 3 tax-exempt status on IRS/Department of Treasury letterhead, etc.

     c) Refuses to agree to the terms and conditions statement as part of the SLRC Agency Information Form

     d) Has been in existence for less than 3 months unless the agency is affiliated with a large, well-known national company or organization; or a unique, much needed service is provided in the community, for example: emergency services during a time of disaster, flood, etc.

     e) Does not have an established address, phone, and a consistently available contact person. In addition, it is strongly recommended that an email address be established for quick streamlined and paperless update processing

     f) Serves members only, or a very narrow population

     g) Has a documented history of fraudulent or illegal activities

     h) Misrepresents services offered in any way

     i) Is not licensed (in areas where licensing laws, regulations, and/or standards exist)

     j) Does not respond when asked to update information

Process Steps for Applying the Inclusion/Exclusion Criteria

1) Agencies applying for inclusion on the Resource Database will required to complete a SLRC Agency Information Form, a SLRC Service Information Form, and, if necessary, a SLRC Site Information Form.
2) Agencies may obtain the required forms by contacting a trained SLRC resource specialist, the BEAS SLRC Program Manager, or by downloading the forms from the SLRC website. Completed forms will be submitted to a SLRC or the BEAS State Office. Upon receipt of the submitted forms, the receiving office will forward the packet to the SLRC that serves the area that the agency's physical address resides within (as reported on the SLRC Agency Information Form).
3) The forms will be processed and an inclusion/exclusion decision will be made within three weeks from the date of submission.
4) If an agency does not meet the criteria for inclusion in the Resource Database, the agency will be informed of the denial decision, and the reason why, by telephone, fax or email.
5) If there is a challenge to the denial, a meeting between the trained resource specialist who made the decision and the agency will be scheduled to explain the reason(s) for denied inclusion, and to hear any new information that the agency wishes to present.
6) If the agency is still not satisfied, a meeting with the BEAS SLRC program manager and the agency will be scheduled to discuss the reason(s) for the denied inclusion. The BEAS SLRC program manager's explanation and decision is final.

Disclaimer

1) The inclusion/exclusion criteria listed in this policy should not be considered a complete list. Final decision for inclusion is the responsibility of the BEAS SLRC program manager.
2) BEAS, in partnership with the SLRC network, may exclude or remove organizations from its resource database for any reason. Inclusion in the database does not imply endorsement, and omission does not indicate disapproval. The SLRC network neither guarantee nor make representation as to the accuracy or completeness of the information contained in its database. The SLRC network disclaims any and all responsibility and liability that may be asserted or claimed resulting from or arising out of reliance upon the information and procedures presented in the database. The SLRC network does not guarantee the programs included in the database will accept referrals. The database is for informational purposes only and not for advertising/sales. The SLRC network reserves the right to edit information to meet format, guideline, and /or space requirements. Every attempt will be made to list appropriate agencies, organizations, and community groups that meet the criteria contained in this policy.

The ServiceLink Network Definition of "Unmet Need"

The ServiceLink Network strives to record contact information uniformly and consistently. Accurate and consistent reporting allows us to demonstrate that the public money invested in ServiceLink is well spent.

Properly recorded information also helps us identify and document needs that cannot be addressed because services are inadequate or non-existent. For ServiceLink Network purposes, "unmet need" indicates that the client experiences negative consequences because the required service does not exist, is not financially or geographically accessible to the client, or lacks the capacity to serve the intended population.

If the client simply "desires" a service, or refuses a referral because they are seeking a "better option," the ServiceLink Network does not regard this as an "unmet need."

Defining "Unmet Need"

An unmet need can be recorded if the consumer meets all of the following three criteria:

➢ The consumer requires a specific service "immediately"*;

➢ The consumer is "at risk"*; and

➢ The consumer is a "willing consumer"*.

Classifying "Unmet Need"

Doesn't Meet Criteria
The individual does not meet the specific criteria of an existing and available program (the service could not be provided to that person).

No Capacity For Transport
The individual does not have the capacity to transport themselves, or to be transported, to the service.

Program Has No Capacity
The identified service does exist, but the program lacks capacity to offer it to the individual. (This applies to programs that are putting potential clients on waiting lists because they are full, or because they lack the necessary human resources to provide the service.)

Consumer Couldn't Pay
While the service is available, the client could not pay for it, or financial aid (whether public or private) was not available.

Community Unmet Need
An unmet need that cannot be met and does not meet any of the above categories can be documented as a "Community Unmet Need" (i.e.: support group that does not exist).

* Definition provided

Definitions*

IMMEDIATE: A consumer's needs are defined as immediate if the need is within two weeks or at the time of follow-up when all available options have been exhausted.

AT RISK: A consumer is defined as "at risk" if he/she is at risk of losing or have already lost a basic human need.

WILLING CONSUMER: If available, the service would be used by the consumer regardless of opinion.

BASIC NEEDS: The six basic needs are food, housing/shelter, material goods, temporary financial aid, health & safety and transportation.
Examples:
Food: commodity foods, home delivered meals, food pantries, congregate meals, farmer's markets, and soup kitchens.
Housing/Shelter: emergency shelter, homeless shelters, home loans, subsidized housing, ramp construction, transitional housing, and utility connection/repair.
Material Goods: automobiles, appliances, heaters, linens, clothing, furniture, and adaptive furniture.
Temporary Financial Aid: housing/rent payments, burial expense assistance, medical expense assistance, health insurance premium assistance, and bus fare or gas money.
Transportation: local transportation, paratransit programs, bus passes, senior center bus services, and medical transportation.
Health & Safety: activities of daily living (ADL) such as: dressing, bathing, toileting, transferring, and eating and instrumental activities of daily living (IADL) such as: doing laundry, shopping, money management, and preparing meals.

* Definitions pertain to the use by the ServiceLink Network for the purpose of defining unmet need.